Bupa Care Homes (ANS) Limited

Meadbank Care Home

Inspection report

Parkgate Road
Battersea
London
SW11 4NN

Tel: 02078016000

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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 overall rating for this service is 'Inadequate' and the service therefore remains 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."

We have also taken the decision to leave Meadbank in special measures because since our inspection in August 2018 several serious safeguarding alerts have been raised which are being investigated by the local authority safeguarding team and the Police.

We carried out this unannounced comprehensive inspection on the 8 and 9 August 2018. At our last inspection in January 2018 we found five breaches of regulations and rated the service as 'Inadequate' and the service was placed in 'special measures'. Special measures provide a framework for services rated as inadequate to make the necessary improvements within a determined timescale. If they do not make the necessary improvements, the CQC can take further action against the provider, including cancelling its registration.

The breaches of regulations we found at the inspection in January 2018 were in relation to safe care and treatment, premises and equipment, staffing, receiving and acting on complaints and good governance.

This was because the provider did not have effective systems to assess, review and manage the risks to the health and safety of people and did not do all that was reasonably practicable to mitigate any such risks. They did not ensure that care and treatment was provided in a safe way for people in terms of preventing,

detecting and controlling the spread of infections. They did not ensure the proper and safe management of medicines. They did not ensure the premises and equipment used by people was clean, suitable for the purpose for which it was being used, and properly maintained. Staff did not receive appropriate support, training, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform. They did not have an appropriate system in place to receive, respond to, and act upon complaints. They did not ensure that systems or processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided. They did not maintain securely an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to people or other records of the management of the regulated activity.

Two of the breaches, 'safe care and treatment and good governance' were so serious we issued 'Warning Notices' against these breaches and required the provider to ensure the breaches were met by 1st May 2018. The provider sent us a report to say how they had met these two breaches and we checked at this inspection that they had followed their action plan.

We also asked the provider to complete an action plan to show what they would do and by when to improve the key questions 'Safe, Effective, Caring, Responsive and Well Led.' We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadbank Care Home on our website at www.cqc.org.uk.

Meadbank is a care home; people receive accommodation, nursing and 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 home is registered for 176 people and 122 were receiving care on the days of the inspection. The home is based on four floors, each named after a different London bridge (Albert, Chelsea, Lambeth and Westminster). Each floor has a private wing and the private wing is collectively called "London Bridge". The number of people and staff on each floor varied in response to their needs. Two of the units specialise in providing care to people living with dementia.

Shortly after our previous inspection we received information that the registered manager was no longer working at Meadbank. The provider has since employed a new manager who has recently registered with CQC. 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.

With regard to the breaches of regulation we found in January 2018 we found the provider had acted to improve the regulations and the outcomes for people. However, there was still more progress that needed to be achieved to ensure people received the care and support they needed.

The only breach of regulation that had been fully met was in regard to complaints. The provider had established a new system to record and monitor complaints and concerns and had investigated historic complaints to ensure these had been fully dealt with.

With regard to the breach of regulation in relation to staffing, we found that the provider had not followed their action plan to meet the legal requirements of this regulation. Systems to support staff through one to one supervision, training, staff meetings and the need to ensure there were sufficient staff to meet people's needs had not been established.

With regard to the breach of regulation in relation to safe care and treatment, we found that the provider had taken action to improve this regulation, the assessments of people's needs, risk assessments and actions to control the spread of infection had all been improved. Staff were familiar with the different signs of abuse and neglect, and the appropriate action they should take to report its occurrence. However several very serious safeguarding concerns had been reported to CQC, the local authority and the Police, which may mean that people were still not being cared for in a safe way.

Medicines were managed safely and people who had behaviours that may challenge had better access to other professionals for the help they needed.

With regard to the breach of regulation in relation to premises and equipment, we found the provider had taken action to ensure the premises were cleaner and fit for use and had taken further steps to eradicate the long term vermin problem the home had.

With regard to the breach of regulation in relation to good governance, we found that the provider had employed a new manager and had established a home improvements team who were working with the registered manager and staff to improve the home. The systems that had been started were not sufficient to identify all the concerns that we found during this inspection.

Staff were familiar with the different signs of abuse and neglect, and the appropriate action they should take to report its occurrence. The service had carried out proper recruitment processes and checks with staff. These checks helped to ensure that people were cared for by staff suitable for the role.

People's nutritional needs were being met but there were still areas that needed to be improved. For example, ensuring drinks were always within reach of a person and offering snacks between the last meal of the day and breakfast the next day. Staff were aware of the different diets that people needed and people's religious beliefs or personal preference for food were being met.

The service had taken appropriate action to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed. DoLS were in place to protect people where they did not have capacity to make decisions and where it is deemed necessary to restrict their freedom in some way. We saw and heard staff encouraging people to make their own decisions and giving them the time and support to do so.

We observed that most but not all staff greeted people warmly and by their preferred name. There were still occasions when people were not treated with as much respect and dignity as they should have been.

People and relatives were now more involved in the development of their care plans. Care plans had improved; most were written in a person-centred way and focussed on the person's care needs, abilities and choices.

During this inspection we found several continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.These were in relation to safe care and treatment, premises and equipment, staffing and good governance. We also found two new breaches of regulations in relation to dignity and respect and person centred care. You can see what action we told the provider to take at the back of the full version of the report.

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 as it could be.The provider had not taken sufficient steps to improve the safety of people or premises and therefore the rating cannot be changed and will remain as 'Inadequate.'

The provider systems to assess, review and manage risks to ensure people's safety were not working as well as they could be.

Records showed that at times there were still insufficient staff to meet people's needs.

The administration of medicines was managed well.

The provider had suitable arrangements to help protect people against the risk of abuse.

Is the service effective?

Requires Improvement

The home was not always effective.

People were still not supported as well as they could have been by staff who were knowledgeable in understanding their needs because they did not receive appropriate training and support.

Effective arrangements to support people with their healthcare needs had improved.

The service was meeting the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The home was not always caring.

People's privacy and dignity were not always respected.

The level of care people received varied depending on which unit they lived on.

Many but not all the staff were caring towards people.

Is the service responsive?

Requires Improvement

The home was not always responsive.

Care plans had improved to take into account people's changing needs.

The provider had improved their programme of activities; however not everyone at Meadbank was able to access activities of their choice.

The provider had a complaints policy and a procedure to respond to people's concerns and complaints.

Is the service well-led?

Inadequate

The home had a newly registered manager and progress was being made to improve the service people received.

The provider's quality assurance systems had improved but did not always reflect the concerns we had identified at this inspection and therefore the rating cannot be changed and will remain as 'Inadequate.'

Meadbank 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 comprehensive inspection was carried out to see if the provider had followed their action plan to improve the service.

Meadbank was also subject of an 'all home' safeguarding concern where the local authority had placed an embargo on any new admissions to the home from 19 December 2017. This embargo on places was lifted in July 2018 following an intense time of improvement that satisfied the local authority that Meadbank had improved sufficiently to accept new people into the home. The exception to this was the respite service, only people who had previously received respite care could again receive this service from Meadbank.

This inspection took place on 8 and 9 August 2018 and was unannounced on the first day. We told the provider we would be returning on the second day. Data the provider gave us was analysed on 13 and 14 August 2018.

The inspection was carried out by four CQC inspectors, four experts by experience and two specialist advisors who were both senior registered nurses. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service for example elderly, dementia and palliative care. Another CQC inspector analysed the data given to us at the inspection, including staff rotas and training records.

Before our inspection we reviewed information we held about the service. This included statutory notifications received from the provider since the last inspection and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

During the inspection we gathered information by speaking with 42 people living at Meadbank and 11 relatives and friends who were visiting the home. We spoke with the registered manager, the regional manager, the Bupa quality manager, the clinical lead manager and a total of 40 staff, including registered nursing staff, healthcare assistants, domestic and maintenance staff and the activity co-ordinators.

We observed care and support in communal areas in an informal manner. We looked at 34 care records, 28 medicine administration records (MAR) and six staff records and reviewed records related to the management of the service.

Inadequate

Is the service safe?

Our findings

The provider had not taken sufficient steps to improve the safety of people or premises and therefore the rating cannot be changed and will remain as 'Inadequate.'

On 16 January 2018 we inspected the service and identified a breach of the regulation in relation to safe care and treatment, this was also a breach at the July 2017 inspection. The provider did not assess the risks to the health and safety of people because the pre-admission assessments were insufficiently detailed to help build a comprehensive risk assessment for a person. The risk management plans for behaviours that might challenge were not sufficiently detailed. They did not ensure the proper and safe management of medicines. Also at the January 2018 inspection we found a new breach of this regulation safe care and treatment because people were not protected against the risks associated with the prevention and control of infections.

We issued an enforcement 'Warning Notice' against this regulation and required the provider to be compliant by 1st May 2018. The provider wrote to us and told us they would make the necessary improvements and address all the above concerns as required.

At this inspection, we found the provider had made progress in the above areas of concern but there was still more work to be done, to fully meet the legal requirements of this regulation. Since our last inspection no new people have been admitted to Meadbank and so we were unable to look at any new pre-admission assessments. Of the care plans we looked at we did see that assessments of people's care needs had been updated and the information was more comprehensive than previously seen, and information in the care plans was transferred to the supplementary folders that were kept in a person's room. This helped staff to give the correct care and support to a person.

Examples of good assessments of care included a person who had a bed rail assessment for their safety and a moving and handling risk assessment with details of bodily positional changes to be made and when. On one unit all people with bedrails had appropriate risk assessments. The clinical services manager told us, "We try to use the lowest bed position possible and other, less restrictive alternatives to keep people safe instead of bed rails." Other people had moving and handling assessments detailing any equipment that was needed to support them.

We observed one person started to cough while they were being supported by an activities worker. The person's care plan noted they were at high risk of choking. The activities worker responded according to the strategies in the person's care plan. People who smoked were supported to do so safely. We observed one person wore a fire-retardant apron and was supported by staff each time they went to smoke in the courtyard.

We also saw that action had been taken to improve the risk management plans for behaviours that might challenge. The provider had arranged for the local authority 'challenging behaviours' team to visit the home every week, to support people and staff in managing these types of behaviours.

However, despite the good examples above we also saw a lack of detail in other people's risk assessments. For example, there was a lack of detail for a person who was diabetic and the actions to take if their blood sugars were too high or too low. For another person who was at risk of pressure ulcers, there was a body map showing the areas of risk but this information had not been transferred to the person's supplementary notes in their room. This meant staff had not acted to reposition the person, to help prevent the risk of further pressure sore areas. We spoke with the registered nurse about this and they agreed there was a discrepancy between the nursing assessment for skin integrity and supplementary notes and action would be taken immediately to remedy this.

Body maps were completed monthly and updated when there were concerns about a person's skin integrity. However, although the home had people who were at risk of pressure sores and specialist mattresses were in place, there was a lack of consistency in the use of turning charts or clear plans of action to prevent skin damage. We saw that not all people who were bedfast had a turning chart. We asked a registered nurse about this and they said that turning charts were used "if someone has a sore or were end of life" We observed during our two days some people in the same position for more than four hours, which would not help with the prevention of pressure sores.

Another person was assessed as being at risk of isolation, but records showed that no consistent action had been taken to help this person with this isolation. Another risk assessment showed a person was at high risk of falls but on the same date it also stated they were only at medium risk of falls. There were no notes of intervention by the physiotherapist since 2016, to support staff and the person to reduce their risk of falling. We looked at the risk assessments of a person who fell during our inspection and found that although staff knew the person was generally unsteady, there was no recorded assessment by the physio or occupational therapists. This person's supplementary folder included a section 'Key Safety Risk' but made no mention to the person's unsteady gait, their poor nutrition, or their risk of slips and falls. The lack of details we found and clear actions staff should take to keep people safe meant that people were still at risk. The concerns identified in the above paragraphs continue to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicine administration charts (MAR) we looked at included a photo of the person and any known allergies and overall we found these were correctly completed. The time taken to complete medicine rounds had improved and people were receiving their medicine as prescribed by the GP. Medicine storage was good, new and additional medicine trollies had been purchased which made the storage and security of medicines better. All staff who administered medicines had received updated training and their competency had been checked. This included agency staff who administered medication. We saw that an up to date record of the names, signatures and initials of staff competent to administer medicines had been maintained.

Our observations of medicine administration showed that this was done safely. We saw that nurses asked people if they needed 'as required' (pro re nata or PRN) medication such as pain relief before preparing and administering it. Nurses stayed with people and supported them to swallow their medicines before signing the MAR. Documentation for each cream or lotion was available and we saw that administration records were up to date. We checked the count for several medicines at random, including some controlled medicines and the actual count matched the expected count in all cases.

Staff administering medicines had access to the medicines policy of the home, NICE guidelines, patient information leaflets and a copy of the British National Formulary (BNF). This helped staff to keep up to date about diverse medicines and be able to respond to questions from people living in the home. Medicines no longer required were stored and recorded safely and disposed of appropriately. Medicine errors were

investigated and actions taken to help avoid similar errors in the future.

Improvements had been made to the cleanliness of the home and the provider explained a deep clean of parts of the premises had taken place. We saw that new flooring had been fitted throughout the service, replacing the old and worn flooring we found at our previous inspection. One unit which had previously smelt strongly of urine, now smelt fresh and clean. The unit kitchens were much cleaner. People's rooms and all of the communal areas were cleaner. We spoke with several domestic staff including the housekeeper who told us, "Things are lot better now. The equipment I need is always available" and "We had new training and it was really practical, showing us how to mix the chemicals and which mop or cloth to use and when." We observed one cleaner was now working with colour coded equipment which she was able to explain.

On 16 January 2018 we inspected the service and identified a breach of the regulation in relation to premises and equipment. Because the provider did not ensure the premises and equipment was clean, suitable for the purpose for which they were being used, and properly maintained. The provider wrote to us to say what they would do to be compliant with this regulation and improve this key question to at least good.

At this inspection, we found the provider had made progress in the above areas of concern but there was still more work to be done, to fully meet the legal requirements of this regulation. The home had employed a new contractor to help eradicate the vermin and was taking steps to seal up possible points of entry. Staff told us there were a lot less sightings of mice now. We saw the unit kitchens were cleaner, with new rubbish bins and waste food being disposed of quickly and not left in uncovered bins. Where required new fridges, kettles and heated trollies had been purchased.
The home was gradually being painted and bathrooms and sluice rooms were overall clearer than we had seen before and could now be used for the purpose they were meant for. We did see that one of the sluice rooms was not locked on both days and we spoke to staff about this. Also on the second floor there were two self-contained studio flats, consisting of a bedroom/lounge area, bathroom and kitchen. They were used to help rehabilitate people before they returned home. The flats were not being used at the time of the inspection. However, when we looked into one of the flats that was reached via an unlit corridor we found a person alone in the bathroom. Within this area we also found an unlocked room that was extremely hot and again unlit. We called staff to help the person return to the main unit. We also saw several rooms which workmen were refurbishing or repairing were left unlocked when they were not there. Tools and equipment that may be hazardous to people were left in the rooms. We spoke with the registered manager to ensure the flats and other rooms were locked when not in use.

When asked about the call bells people commented "The night staff are better than the day staff because when you call the night staff they will come, the day staff will step in turn off the bell and go. Sometimes you wait for over half hour they don't want to hear the bell," "I can call [the call bell] but wait. They [staff] are far away and I wait for a long time, they are looking after others. I shout please look after me" and "The call bell is there, I can use it if I need to. Staff come as quickly as possible." We saw that emergency call bells were mainly within reach of people when they were in their rooms or in the main communal areas, although we saw that some people were unable to use them. When we asked staff about this we were told that there was no other system in place to check on a regular basis if people needed any assistance.

When we pressed the emergency call bell because a person had fallen, it was not responded to and we waited 20 minutes for staff to pass the person's room and give help. On day two we looked at the print out of the number of times and when the call bell was used from the previous day. Our call was logged and in the same time frame also showed as having been turned off. We saw this happen several times within other time

frames. One person had rung their bell 20 times and each time it was immediately turned off. Staff told us that when their emergency bleeper breaks they are not being replaced as a new system is being installed but the alarm sounds in the corridors of the units. During our two days on site we did not hear the alarm sounding. The provider told us they were having a new emergency call bell system fitted which would be easier to use and more efficient. The concerns identified in the above paragraphs continue to be a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where necessary portable appliance tests (PAT) had re-inspected items without a current label to ensure they were safe to use. The Food Standards Agency (FSA) inspected the kitchens in February 2018 and gave a rating of 5, where 1 is poor and 5 the highest rating. The FSA inspector said the hygienic handling of food including preparation, cooking, re-heating, cooling and storage and the cleanliness and condition of facilities and the building (including having appropriate layout, ventilation, hand washing facilities and pest control) was good.

On 16 January 2018 we inspected the service and identified a breach of the regulation in relation to staffing. The registered person did not ensure there were sufficient staff on duty to care and support people in a timely manner. The provider wrote to us to say what they would do to be compliant with this regulation and improve this key question to at least good.

At this inspection we found the provider had not fully followed their action plan to ensure there was sufficient staff on duty at all times. We analysed the staff rotas for April, May and June 2018 and found the number of staff on duty during the day continued to be inconsistent. For example, on one unit over a two-month period we found the number of nursing and care staff working on each shift during the day varied between seven and nine staff. In one instance the number of nursing and care staff working a shift during a weekend fell as low as five because of staff absences due to a combination of annual and sick leave. In addition, staffing levels during the day on another unit varied considerably with between seven and 11 staff on duty during the week, and again at weekends with staffing levels ranging from seven to nine staff on shift. Similar issues in relation to the consistency of staffing levels were identified at night for one unit during the months of April and May 2018. We found nursing and care staff numbers varied considerably at night with anything between one and four staff on duty in April and May 2018. The concerns identified in the above paragraph continue to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A senior nurse told us that nurses and support workers from agencies when used to provide support to a unit, it was the unit's policy to ensure that all agency staff worked with a regular member of staff for continuity. If an agency member of staff was seen to not be following procedure such as moving and handling, infection control and care planning they would be asked to leave and reported to the agency and not used again.

We saw that although each person had a personal emergency evacuation plan (PEEP) in place, which explained the help they would need to safely leave the building, these were not as up to date as they needed to be. We compared the information held on one unit with the information held in the fire exit area, which is the copy the emergency services would use to evacuate people. Of the 28 records we looked at eight were incorrect, rooms showing as occupied were now empty, people showing as able to mobilise were now bedfast and another person was listed in two rooms. The PEEP only had the person's room number and not the person's name. We spoke with the registered manager about this, they explained this was a form provided by Bupa and that there was not a space to put a person's name only their room number. He said this would be amended immediately.

Regular fire drills were held, with actions to take if the staff actions had not been as required during an evacuation. Fire extinguishers were serviced in March 2018. Contingency plans were in place should the home become unusable.

Records confirmed staff employed underwent pre-employment checks to ensure their suitability for the role. These included photo identification, proof of address, references and a completed Disclosure and Barring Services (DBS) check. A DBS is a criminal records check which employers undertake to make safe recruitment decisions. Staff completed an application form and were interviewed before recruitment.

People and relatives we spoke with said they felt safe living at Meadbank. Staff could describe how to identify, report and escalate suspected abuse. Staff confirmed they would inform the registered manager or nurse on duty of any suspected abuse and if they felt this wasn't being addressed appropriately they knew how to raise matters under whistleblowing procedures. Staff told us that they had received safeguarding training. However several very serious safeguarding concerns had been reported to CQC, the local authority and the Police, which may mean that people were still not being cared for in a safe way.

Accidents and incidents were generally recorded, investigated and changes made to people's support to prevent re-occurrence. There was a flowchart in each nurse's station reminding staff of the process to follow to report incident and concerns. Incidents were graded according to severity which determined whether they were added to the service's clinical risk register and discussed at the clinical risk meetings. Incidents of severity grade three and above were also reviewed by the regional director. All incidents were also discussed at the daily take 10 meetings. We saw that some incidents had resulted in staff undergoing coaching, additional training and in some cases, disciplinary procedures and dismissal. We saw lessons learned were discussed at unit meetings and in regular and extraordinary supervision meetings with individual staff.

Whistleblowing protocols were in place and staff had opportunities to speak confidentially about any issues they had. The Speak Up service within Bupa allowed all reported concerns to be directed to a website and regional officer where support was given to the whistle-blower for any concerns. The home also held staff forums to allow people to speak about any concerns they might have.

Requires Improvement

Is the service effective?

Our findings

On 16 January 2018 we inspected the service and identified a breach of the regulation in relation to staffing. The registered person did not ensure that persons employed received appropriate support, training, professional development and supervision because the practice of individual supervision had become very infrequent, staff training was not up to date and a recommendation by the Fire Risk Assessment conducted in November 2017 that all staff should complete the fire awareness training had not been met. The provider wrote to us to say what they would do to be compliant with this regulation and improve this key question to at least good.

At this inspection we found the provider had started to follow their action plan and had improved their support towards staff, however the programme of supervision and appraisal implemented by the newly registered manager had only been in place since May 2018 and there was not enough evidence to demonstrate that it had embedded itself in the home's overall practice or culture or that it would be sustained.

Initially we were provided with records which indicated that staff had not received supervision since April 2018. However, when we enquired further, the registered manager was able to show that a new system of staff supervision had been introduced and we saw examples of staff supervision which had taken place in June and July 2018. The registered manager told us that the intention was that staff would have formal supervision sessions with their managers between three and four times per year, held in between appraisal and goal setting sessions. At the beginning of the year there would be an initial goal setting and development meeting, followed by two supervision sessions. A mid-year review would follow which would review progress to date and this would be followed by two more supervision sessions. At the year-end there would be a final review which would provide an overall appraisal of staff performance for the year. This system was not yet fully up and running. In the meantime, staff supervision was being carried out on an ad-hoc basis via tasks allocated at handover sessions and through information provided at staff meetings.

Meetings took place amongst the various staff groups, such as care staff, laundry and maintenance teams or catering staff. However, these were infrequent and the recording of action points was poor. In many instances the record of the meeting consisted only of the notice that there was to be a meeting, but nothing further was added. Some meetings had agendas but no action points or minutes that would assist staff later on. We saw four meetings booked for the laundry, maintenance and activities teams for June and July where there were only invitations with no indication as to whether the meetings actually took place. A staff meeting for April had an agenda but no notes. A care worker and a nurses meeting held in July had agendas with a list of attendees, but again no action points.

We also found in January 2018 that not all staff had received up to date training in some key aspects of their role including, moving and handling, fire safety awareness and Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This meant not all staff had the right levels of knowledge and skills to effectively perform their roles and responsibilities.

At this inspection records indicated staff training had improved in the last six months with over ninety percent of staff now being up to date with their mandatory training, compared to less than seventy percent in January 2018. For example, most staff had now received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and completed dementia awareness, preventing and managing behaviours that might challenge the service, medicines management level one, nutrition and hydration and pressure sore prevention and care management.

However, these improvements described above notwithstanding, we still found shortfalls in staff training. Records showed approximately between ten and thirty percent of staff had not updated their people moving and handling, medicines management level two, fire safety awareness, basic food hygiene, the safe use of bedrails and safeguarding adults training. This ran contrary to the provider's training policy which stated it was compulsory for all nursing and care staff to continually refresh their knowledge and skills in the aspects of their work. The concerns identified in the above paragraphs continue to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that meetings for the catering team had taken place and covered topics such as fire training, kitchen cleanliness, meal times, ensuring professional appearance of staff and allergies and other dietary requirements. The minutes for these meetings were the most comprehensively completed, with names of staff who attended, an agenda and the action points from the meeting.

Staff spoke positively about their work and about the recent changes to the service. One member of staff told us "Quite a lot has changed and it is for the better. It seems more for the residents now." Examples given to us were that clearer direction was provided to staff regarding their duties and a greater emphasis on managing punctuality and sickness. Another member of staff said, "I think it has got better. You can go to the manager if you want to talk about something, and you see more managers coming to the floors to walk around." Another member of staff said, "I have received good training and we work as a team, although it is difficult if there are a lot of agency workers as you have to keep an eye on them and remind them what to do."

On 16 January 2018 we inspected the service and identified a breach of the regulation in relation to access to other healthcare professionals. Staff did not always support people in a way that met their health needs because actions had not been taken to minimise the pain and discomfort to people by the prompt intervention of other healthcare professionals.

At this inspection we found the provider had followed their action plan and had improved the support given to people and people's access to other healthcare professionals. The original GP surgery gave Meadbank notice that they would no longer be able to provide a GP service to the home and that a new GP surgery would need to be found. Meadbank worked with the local authority, the local Clinical Commissioning Groups (CCG) and NHS England to secure a new GP service. A new GP service based in the Wandsworth borough was due to start delivering services to the home from 1 September 2018. In the meantime people received care through a GP locum service. Records showed that people were seeing associated health professionals, including recent visits by the wheelchair service, the tissue viability nurse (TVN), community psychiatric nurse (CPN), dietitian, optician, dentist, podiatrist and the internal physiotherapy service.

The clinical services manager also told us that from 13 August there would be an Advanced Nurse Practitioner working in the service, for six months. Their role would be to improve the clinical support provided by the service, and improve access to community health services. They would also be able to prescribe medicines which would help people to access prescriptions in a timely manner. They would also have a role in providing specific, clinical training and coaching to nurses and care workers. One person

commented that they enjoyed living at Meadbank and staff looked after him well. Their records showed that staff were quick to respond to his specific healthcare needs and get help and further advice when required.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA).

The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had arrangements in place to assess people's capacity in regard to making specific decisions. We saw that people's capacity to consent to their care had been assessed and the provider had made the relevant applications to the local authority for authorisation to deprive several people of their liberty.

People were supported to give consent to their care as far as possible. Where people were unable to give consent, the staff understood how to make decisions in people's best interests. On one unit documentation relating to decision-making and application of the MCA was clear in people's records. People had signed to demonstrate they consented to their care and people's fluctuating capacity was noted in their records. For example, someone who preferred to sleep on the floor on a mattress had had a best interest assessment carried out regarding their safety and mobility to ensure that the person could still enjoy a good sleep.

However this good practice was not seen on all the units. On one unit information about people's capacity was not always included in their care plans. Original copies of the DoLS were kept in the office but the details of what part of a person's liberty had been restricted was not always transferred to the care plans or supplementary plans, which may mean that staff were unaware of a restriction on a person's liberty.

Where the care plans stated another person held 'Lasting Power of Attorney' (LPA) a copy was not in the file and it did not say what the LPA was for, for example, health and welfare or finances, and staff could not tell us. Similarly, when the care plan stated the person had an 'Advanced Directive or Living Will', a copy was not in the care plan and no further details were available to ensure people received the care they want. An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision a person can make at any time to refuse a specific type of treatment at some time in the future.

Overall we found that staff and management understood the principles of the MCA and DoLS. The registered manager told us they were reviewing everyone's DoLS and where appropriate reapplying to the local authority to restrict a person's liberty where this was necessary for the person's safety.

Staff supported people to eat and drink sufficient amounts to meet their needs. The dining rooms were nicely set and clean. Staff were aware of people who were on special diets and these were noted on a whiteboard on the wall of the dining room outside the kitchen, with their initials. We saw people were served the appropriate special meals.

Although we found some shortfalls in the recording and monitoring of fluids and food there was a well-planned menu which offered nutritious meals in a variety of choices. We saw that the menu that was displayed accurately reflected what people were given. The menu reflected the choices that people had made and had taken religious and cultural preferences into account. The meals were prepared in the main kitchen and served on each floor by kitchen assistants from a hot food trolley. The meals we saw were presented in an appetising manner. Staff assisted people to eat when required, in a calm and unhurried manner. We saw that people had been referred to the Speech and Language Team (SALT) or dietitian where appropriate.

The evening meal took place at 5pm. After this time there was a menu called "Nite Bites". This was designed to offer people nutritious snacks later in the evening when the main kitchen was closed. Sandwiches, beans on toast, soup and fruit purees were on offer and clearly displayed on a board. We asked how people were made aware of these evening snacks and how they asked and made their choices. The staff told us they would explain what there was, and at other times staff would ask people if they would like something to eat. However, on one unit around 12 people were bedfast and most other people lacked sufficient awareness of their surroundings to consciously look at the display board or ask for something in a proactive way. We did not see night time snacks recorded in the records we looked at, although we checked the kitchen area and saw that there were all the ingredients in place to provide snacks. People we spoke with said they got a cup of tea and a biscuit at night, but did not mention any of the other snacks on offer.

The home employed a chef, who had developed a four-weekly menu in conjunction with people and their relatives. The chef told us that food was discussed with people at resident meetings and opinions sought through surveys as well as more informal methods. There was a good variety of options on the menu with more traditional options as well as spicier foods such as curries. In addition, there was a list of separate dishes including vegetarian options which could be prepared for people should they not want the main options on any particular day. The chef told us they had introduced new options to the menu following requests from people living at the service. The home had a nutritional lead that monitored nutrition and hydration. Weekly weights were carried out and anyone identified as having a concerning weigh loss was put on a focus list for extra nutritious snack.

Records showed that people were assessed by the speech and language team (SALT) where it was deemed appropriate. Any instructions or directives were detailed in people's care plans. However, the handover sheet that staff were given to alert them to concerns in many cases did not have the necessary information that staff would need. The home employed a number of agency staff and they would depend on this information on the handover sheet to give them the necessary information to keep people safe by alerting them to potential risks. The only indication that people were at risk of choking was whether they had a pureed or a soft diet.

We recommend that the registered manager and staff consider the effectiveness of the current method of offering food and drink after 5pm, in order to be sure that no one is hungry or thirsty between the evening meal and breakfast the following day.

Requires Improvement

Is the service caring?

Our findings

We observed some staff treated people with kindness and compassion during our visit. People commented "They [staff] are very good here, I can't complain about any of it." A relative told us "They [staff] were very quick to respond when my relative was unwell and needed to go to hospital and they were also concerned about me." We also received several positive comments about two named nurses and we passed these on to the registered manager. A compliment we saw noted that staff had organised a wedding anniversary party for one person and "the cake was amazing and such a beautiful surprise."

However, we also received some less than positive comments from people, "I am not happy, Staff give me my medicine and they give me a wash. But they don't talk, they do their job that's all" and "They [staff] can't find any decent clothes for me. These don't fit they are the wrong size and they are not my clothes."

We also heard language being used that could have been infantilising or judgemental or people being called by something other than their preferred name. We heard staff calling a person 'Daddy' even though when we checked it was not their father and the care plan did not note the person liked to be called this. Another staff member addressed a person as a 'good girl,' a person of another ethnic origin was called by a term that was derogatory and we heard a staff member say to a person "If you have a shower, I'll give you two fags [cigarettes]. One person's care plan contained judgemental and restrictive language when issuing guidance to staff regarding someone's personal habits. These examples did not demonstrate a person-centred approach to treating people with respect and dignity.

Also because of people's high level of care needs and the times of staff shortages staff interaction was mainly related to care tasks, such as personal care, assistance with eating or helping someone move from one area to another. We saw on our first day that many people stayed in bed all day. We asked staff about this and received a mixed response, including "people want to stay in bed" "we don't have enough staff to get everyone up" and "I don't know why they are in bed." Many people went for long periods without any direct contact with staff or other visitors. For example, we observed on one unit that those people who were bedfast only had contact with staff in order to receive a care related task, and people in bed with a language or speech difficulty, who relied mainly or solely on staff proactively visiting them to check on them, did not always receive these visits. The concerns identified in the above paragraphs are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Access to staff was not the same on all the units, however. On one unit we saw staff spending time with people whether in their rooms or in the communal areas. People who were in their beds received hand massages from staff, and we saw one staff member singing to another person who was in bed. In communal areas small groups of people were chatting, doing jigsaw puzzles together and listening to music.

People's care plans contained many sections designed to help staff understand the needs and background of people and which aimed at describing people's "My Day, My Life, My Story". Sections included descriptions of people's senses and communication, choices and decisions over care, lifestyle, activity and interaction records. Most of these contained tick boxes against generic descriptions and monthly reviews

(called "evaluations") were mainly checks to see if anything needed altering, or no change. Care records showed that where required, family and others were involved in developing people's care plans and their views were taken into consideration. Important people in the lives of people were recorded.

Staff demonstrated a sound working knowledge of the needs and likes of people. One member of staff was able to describe the improvement in one person's physical and mental health since coming to live at Meadbank, by relating tales of what they were like at the beginning and what the person was able to enjoy now.

The registered manager told us that these care plans were being reviewed with the aim of making them more personal and detailed. As the registered manager had only been in post for four months it was a work in progress.

We saw examples where staff did ensure that they respected people's privacy and dignity. Most people said staff knocked on their door before entering, assisted them discreetly and remained calm and friendly when supporting them. People commented "They [staff] are kind, they couldn't be nicer or kinder". However, some people told us, "They [staff] are not bad or angry, but they don't talk to me, they don't know what person I am." We received several comments from people saying that staff did not talk to them when supporting them or giving personal care.

People's religious and cultural beliefs were respected. People had the opportunity to join in a religious service when a visiting church came to the home. People's nutritional religious beliefs were being met by staff.

Requires Improvement

Is the service responsive?

Our findings

On 16 January 2018 we inspected the service and identified a breach of the regulation in relation to complaints. The provider did not have an appropriate system in place to receive, respond to, and act upon complaints because there was no central recording system for complaints. The provider wrote to us to say what they would do to be compliant with this regulation and improve this key question to at least good.

At this inspection we found the provider had followed their action plan and had improved their process for responding to complaints. We saw that each complaint received had been acknowledged, investigated and responded to. Investigations were thorough and the service had apologised and in some cases, reimbursed people where staff were found to have been at fault. We saw that the interim management team had responded to some historical complaints that had not been responded to by the previous management team, sometimes a year after the complaint was initially received.

The complaints procedure and invitation for people to provide feedback was clearly displayed, together with the details of other organisations people could contact if they were unhappy. This was particularly useful for families and visitors. However, the dependency levels of people and their cognitive skills would make it difficult for everyone to be able to complain in this way and we did not see an easy to understand or read version of the complaints process.

Care plans were generally well written and included information about people's physical support needs, likes and dislikes, as well as personal histories and preferences to assist staff in identifying what was important to each person. There was also a supplementary file that included a 'My Life, My Profile, My Details' and daily observations and recordings. People and those close to them were encouraged to contribute to the assessment and planning of care. Since our last inspection all care plans had been reviewed and updated as part of the 'Resident of the Day' scheme. One person on each unit, each day received a special meal of their choice, had their room checked and their care plans and risk assessments reviewed.

A lot of effort had gone into the process of care planning and risk assessments however the outcomes for people were not always realised as there was an absence of person centred care at the point of delivery. For example, people's rooms in some case were not personalised, some rooms had no pictures, personal items, clocks or a calendar. We also saw that some clocks were on the wrong time or had stopped and calendars did not display the correct date. Preferences to listen to music or watch the television were detailed in care plans but this was not always evident in people's bedrooms.

We saw one person liked a wash or shower and to get dressed each day but the daily records indicated they had gone two days without a wash or help to dress because staff were too busy. Another care plan said the person had full capacity and liked to make their own decisions, but another section said a family member had been asked before the person could go on an outing to the park.

Another person was seen to be drinking alcohol, bought when they were out with a staff member but whose

care plan indicated this would not be good for them. We asked the nurse in charge of the unit and they said they were not aware they should not drink alcohol and the staff member did not realise what had been bought was an alcoholic drink.

Despite the wide range of options, which the home's activities coordinators had worked hard to develop, there was little evidence of a healthy take up of these options. The degree of dependency of people, the numbers of people who were bedfast and the demands on staff time meant that there was not much in the way of activities on some units, which made it difficult for all people to socialise, take part in activities or have some meaningful individual attention.

One person told us, "I would like a game of cards. This is not a life. If no one comes to see me I sit here all day. The light is not good enough and I'm on my own. They need to put me somewhere where I can interact with people". Another person said, "I can't do activities, I haven't got proper clothes on, [they explained what they meant by this]. I like to listen to music." There was no music was on in the person's room, despite a radio present. The CQC member of staff put the radio on for the person and they thanked her. A third person told us, "I don't go anywhere as I will need someone with me. I ask them to open the door and they [staff] say we are too busy and walk off". A relative told us "The staff say my relative refused to go to bed because it's still light and she doesn't want to sit in the common room, but there's no stimulation, the staff are not interested in engaging with people, they just sit there and are ignored."

We saw that on each floor and in the main reception there was an activity planner which was attractively designed and which described various activities for different days of the month, with each month having a new selection. We saw that there were activities such as bingo, nail care, reminiscence, art club, sports club and zoo lab, on different days of the month and on different floors. However, the positioning of the activities board and the design was adequate for someone who could read and understand days of the week and which week and floor something would be happening but may not be understood by someone with a cognitive impairment. There was no other indication of what was actually taking place that day.

The activity co-ordinators had also organised external outings to the local Battersea Park, celebrations of important days, such as Victory in Japan (VJ) Day, and India and Jamaica Independence Days. The service had made photo books of various activities that had taken place. These showed people enjoying themselves at trips out to places such as Hampton Court Palace and Battersea Park. Other activities advertised for this month were a men's club, art club, mobile library visit, and a zoo lab visit. The manager told us that the service was recruiting additional staff for activities and moving to a seven-day activities provision (instead of only five days).

The home had information on how people had spent their time prior to admission to the home and with their interests and hobbies, however, there was little evidence that this information was acted upon. People being looked after in bed did not always have individualised plans, some care plan said they had 'one to one' time with staff but there was no information of what that entailed.

There were multiple examples of people who were looked after in bed with no stimulation, no radio, television, books, magazines or newspapers. Where music was playing it was the same music channel playing in every room, which may not reflect personal choice. The one to one interactions we saw recorded were not daily, with some people not having any recorded interaction or stimulation for three or four days. For example, for one person this one to one time with staff was recorded as "I went and said good morning to [the person] and she smiled". This entry was repeated multiple times and according to records these one to one sessions were carried out 10 times in the month of July.

Some, but not all, care staff appeared to be uninvolved with how people spend their time and had little knowledge of the existence of life history and how people preferred to spend their time. This may be because we saw that for team meetings the activities team was aligned with the laundry and maintenance team. We discussed this with the resident experience manager why the activities staff were not with the care staff or unit staff. We discussed the possibility of the home considering making the activities staff more aligned with the care teams, experiencing handovers, care plans and actively working with them, which may give them a better understanding of people's needs and care staff a better understanding of the importance of activities in people's lives. The concerns identified in the above paragraphs are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to receive the type of end of life care they wanted. We saw that some people had a 'do not attempt cardio pulmonary resuscitation' [DNACPR] directive. These were comprehensively completed, with details of the person's clinical health and the reason for a DNACPR were described, and these were signed and dated by the GP. They were also updated when appropriate. Where people had an active DNACPR in their file, they also had a coloured dot on the front of their care records to indicate this.

Inadequate

Is the service well-led?

Our findings

The systems the provider had started were not sufficient to identify all the concerns that we found during this inspection and therefore the rating cannot be changed and will remain as 'Inadequate.'

Our inspection of 16 January 2018 found that the provider did not have effective governance, assurance and auditing systems or processes in place and they had not identified and addressed the number of issues we had found during our inspection. This was also identified as a breach of regulation in our previous inspection in July 2017. The provider did not maintain securely an accurate record in respect of each person and other records of the management of the regulated activity and produce these when asked. The provider had not sent us notification they are required by law to send us. Also, the lack of a dementia-friendly environment or evidence of specialist services for Alzheimer's, Parkinson's disease or strokes as advertised on their web site.

We issued an enforcement 'Warning Notice' against this regulation and required the provider to be compliant by 1st May 2018. The provider wrote to us and told us they would make the necessary improvements and address all the above concerns as required. As part of the local authority 'all home' safeguarding concern Bupa were required to produce a weekly action plan against the areas of concern found at the last CQC inspection and other concerns the local authority had received. We received a copy of this action plan with updates weekly, the last report was received on 7 August 2018.

At this inspection, we found that the provider had employed a new manager and had established a home improvements team. This was a team of senior Bupa staff, with varying areas of expertise in large care home management. They were working with the registered manager and staff to improve the home. This home improvements team were to remain in Meadbank for a period of at least two years.

The provider had made progress in the above areas of concern but there was still more work to be done and there was not enough evidence to demonstrate that the positive changes had embedded themselves in the home's overall practice or culture or that it would be sustained. The systems that had been started had not identified all the concerns that we found during this inspection.

We looked at the audits and checks made by Bupa which they referred to as their 'operational essentials plan.' We saw that care plan and medicines audits took place monthly, on each unit and then an aggregate report was produced for the whole home. Medicines audits had actions that we saw completed with the person responsible and a date for completion. Clinical risks, which were completed monthly on each unit, included MUST, malnutrition, infections and pressure sores were monitored. Each month the clinical services manager compiled a report with action plans to be followed, all of which was making it easier to track progress or the need for further action.

The clinical lead visited each unit in the morning to discuss any nursing concerns and senior staff from each unit and department met daily at a 'Take 10' meeting to highlight any concerns with residents, staffing or the environment. These daily meetings meant action could be taken quickly on any issues raised and the

registered manager could get a clear understanding of what was happening in the home on any given day. There were also daily and weekly clinical risk meetings for each unit.

However, despite all of the good practice being started, the audit system was not always sufficiently robust to identify the issues we found during our inspection. These included a lack of detail in people's risk assessments and a lack of consistency in the use of turning charts or clear plans of action to protect people against skin damage. People's personal emergency evacuation plans (PEEPS) were not up to date and did not give sufficient details to protect people in an emergency. The emergency call bell system was not working effectively. There continued to be a lack of staff to meet people's needs in a timely manner and staff were not supported as well as they could be through training and supervision. We also found the numbers of people who were bedfast and the demands on staff time meant that there was not much in the way of activities on some units, which made it difficult for all people to socialise, take part in activities or have some meaningful individual attention. Some but not all staff showed a lack of respect to people, which did not protect people's dignity. The concerns identified in the above paragraphs continue to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However we also found areas where the improvements were not working so well. The system of handovers and passing information from shift to shift was inconsistent with a different approach used on each unit. A lot of information was given verbally and there was no clear direction for staff on how often people needed to receive drinks, have positional changes, or any additional needs. It was difficult to understand how agency staff would get a full understanding of people's needs with this process.

We recommend the registered manager reviews the handover procedures throughout the service to ensure all staff are aware of people's needs when they start their shift.

The registered manager did tell us about a new style care plan being introduced by Bupa that would be more detailed, with specific care plan areas for sleep and dementia patterns. The new care planning system would also compel a full re-assessment of the person's needs each year. This was being introduced gradually throughout the home starting the week after our inspection, and we will check their progress with this at our next inspection of the service.

With regard to the environment being dementia friendly, we saw that some progress had been made and that the units of concern were brighter and fresher looking but this was more down to the newly painted walls, new flooring and furniture, than action to ensure a dementia friendly environment. People's bedroom doors had recently been painted in the colour of their choice. Their name and photo were on the door, together with the name of their designated key worker, and signage to indicate where the bathrooms and toilets were had improved. These measures would help people to recognise their bedroom and assist them in finding their way around the service.

Each floor had security systems built in regarding access to the lift and to stairwells leading to other floors. This had the positive effect of protecting people from becoming trapped in a lift, or falling down stairs whilst moving unaccompanied. However, it also meant that people stayed on their own floor for most of the day and week. We were told that if there was an activity on another floor, people would be escorted to that floor. Each floor had a lounge area and there was a garden on the ground floor which was accessible and well maintained, however, people on the upper floors would need to be assisted to reach the garden due to their mobility and cognition needs.

As required the service's last inspection rating was clearly displayed in the reception area on the ground floor but not in the reception for the London Bridge unit. This is a separate entrance to the private wing of

the care home. We spoke with the registered manager who said this would be rectified. The main reception area also had a 'You said we did' board: which gave an update on progress in the home. The board mentioned new furniture, outdoor events, personalised music, outdoor 1:1 visits, a night visit to the garden and a day trip. We saw that many of these events had taken place but over the two days we did not see any evidence of the personalised music which was to be put on to memory sticks and played in the lounges for people.

The registered manager was able to locate all the files and records we asked for and was able to explain any changes that had or were being made to ensure files could be located correctly and quickly. From our discussions with the registered manager it was clear they understood their management role and responsibilities with regard to CQC including the requirements for submission of notifications of relevant events and changes. Senior management staff had also been very responsive when we had asked for further information about a notification.

The 'dementia bus' had visited the service monthly since February, to support staff to better understand the experiences of people with dementia. For someone who does not have dementia the 'Virtual Dementia Tour' is proven to be the closest experience of what dementia might be like. The registered manager told us that by staff understanding dementia from the person's point of view they could change their practice, resolve issues and improve people's lives. They said the opportunity to experience the bus would continue for the next few months, and some relatives would also be offered an opportunity to participate.

We saw the staff noticeboard was advertising free flu jab vouchers and mini health checks for all staff and a payment scheme for spreading the payments for appropriate work shoes over three months. Staff awards, rewards and referral schemes and information on forth coming training was also advertised with the ability for staff to sign up immediately, which we saw staff had done for the moving and handling and managing challenging behaviour training sessions.

All the staff we spoke with told us that there had been changes for the better. Staff commented "I can speak with the manager any time. I see him every morning, when he walks around the whole service. I know I can raise any issues I have with him and he will try to help," "We get lots of training," "There are plenty of staff here, we are never rushed [named unit]," "Dignity is very important. I think about my mum, and how she would like it. I always talk to people and chat while doing the personal care," "The place is so much cleaner now. It is so much better," "I have worked here for a long time, and like it. It's a nice place, we work together as a team" and "I always try to stop and talk with people. There's never nothing to do, there is always someone who needs a chat."

Some staff said that there was better discipline, which meant that staff worked better as a team. Other staff said that there was more presence and visibility of the management team, which they felt was a lot better than a manager who stayed in their office. Others said there was a clearer understanding regarding each person's role and who they were accountable to. Staff also said that the changes had improved the overall atmosphere of the home and they enjoyed coming to work. Some expressed concern over what it may be like once they were full with 176 people again, but told us that for now it was ok.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met their needs, and reflected their preferences. Regulation 9 1, (a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect and they had the privacy they required. The registered person did not have due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user. Regulation 10 1, 2,(a)(c)

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 assess the risks to the health and safety of service users receiving care or treatment and did not do all that is reasonably practicable to mitigate any such

risks.

Regulation 12, 1,2, (a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure the premises and equipment used by the service provider was suitable for the purpose for which they are being used, and properly maintained. Regulation 15 1,(b)(e) 2

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not ensure that systems or processes were established and operated ffectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 1,2,(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure that persons employed received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 1,2,(a)