Age Concern Wirral

Meadowcroft

Inspection report

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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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 and 13 May 2015. Breaches of three legal requirements were found. This was because: risk assessments relating to the health, safety and welfare of people using the service were not completed to a satisfactory standard and plans for managing risks were inadequate; assessments were not carried out in accordance with the Mental Capacity Act 2005; medicines were not always managed safely; staff employed by the provider did not receive appropriate support, training, supervision and appraisal; the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook a follow up inspection on 10 December 2015 to check that they had followed their plan and to confirm that they now met legal requirements. During the inspection we found breaches of Regulations 12, 13 and

Summary of findings

17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as a result of our findings we returned to complete a comprehensive inspection of the service on 29 December 2015.

Meadowcroft provides a range of services for older people and people living with dementia. In December 2013, a short stay unit accommodating up to eight people was registered and in April 2015 the number of places provided was increased to 13. The service is also registered to provide personal care for people in their own homes.

The service had a registered manager. 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.

Accidents and untoward incidents had not been investigated and had not been reported to the local authority or to CQC where required. Plans had not been put in place to manage identified risks to people's safety. A significant number of medication errors continued to be reported and no action plan was recorded to address this.

People who used the residential service had a diagnosis of dementia which had an impact on their ability to consent to decisions about their care. People's mental capacity had not been assessed in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been applied for.

Care records were poorly presented and did not give clear guidance to staff about people's individual needs and how their needs should be met.

A range of social activities was provided every day in the day centre and people could choose which activities they participated in. We were told that people had a choice where they spent their time, however there was an apparent expectation that people would spend their daytime hours in the day centre.

There were enough staff to meet people's needs and checks were carried out to ensure that new staff were recruited safely. Shortfalls in staff training were being addressed and all staff had been enrolled to the Care Certificate. A new system of staff supervision had been put in place. We observed staff supporting people at the service and saw that they were warm, patient and caring in all interactions with people. People were seen to be relaxed and comfortable in the company of staff. People who used the service and their relatives told us they were very happy with the service provided.

The premises were clean and bedrooms were appropriately decorated and furnished. Regular health and safety checks of the environment had been carried out. The premises did not provide a homely environment and there were minimal adaptations to help people living with dementia to find their way around.

We were concerned that the registered manager did not have an office within or near to the residential unit and the manager had additional responsibilities that were not related to the regulated activities. There were some audits in place to check the quality of the service, however these had not identified risks to people's health, welfare and safety.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate are significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

Summary of findings

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.

Accidents and untoward incidents had not been investigated and had not been reported to the local authority or to CQC where required. Plans had not been put in place to manage identified risks to people's safety.

A significant number of medication errors continued to be reported and no action plan was recorded to address this.

There were enough staff to meet people's needs and checks were carried out to ensure that new staff were recruited safely.

The premises were clean and bedrooms were appropriately decorated and furnished. Regular health and safety checks of the environment had been carried out.

Is the service effective?

Inadequate

The service was not effective.

People's mental capacity had not been assessed in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been applied for.

Shortfalls in staff training were being addressed and all staff had been enrolled to the Care Certificate. A new system of staff supervision had been put in place.

Is the service caring?

Requires improvement

The service was not always caring.

Staff supporting people were warm, patient and caring in all interactions with people.

The confidentiality of people's personal information was not always maintained.

Is the service responsive?

Requires improvement

The service was not always responsive.

People who used the service and their relatives told us they were very happy with the care provided.

Care records were poorly presented and did not give clear guidance to staff about people's individual needs and how their needs should be met.

A range of social activities was provided every day in the day centre and people could choose which activities they participated in.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

The manager did not have an office in or near to the residential unit and had no visible presence within the residential service.

Quality audits had not identified risks to people's health, welfare and safety.

Incidents of concern had not been reported to the local authority or CQC.

Meadowcroft

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 had addressed breaches of the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 10 and 29 December 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and, on the second day, a specialist professional advisor (SPA). The SPA was a registered nurse with experience in the care of people with dementia.

Before the inspection we looked at information CQC had received since our last visit including the action plan that had been written to address the short-falls we had identified in May 2015. CQC had received two concerns about the service since our last inspection.

During our visits we spoke with five people who used the service, six relatives and six members of staff. We observed activities in the day service lounge and lunchtime in the dining room. We looked at care notes for four people who used the service, medication storage and records, staff training and supervision records, accident and incident report forms, health and safety records, complaints records, and other management records.

At the time of the inspection there were four people living at the home and four people having a short stay there.

Inadequate

Is the service safe?

Our findings

The service had safeguarding policies and procedures and a leaflet gave clear details about recognising and reporting abuse. Training records showed that 13 staff had received training about safeguarding during 2015, but it was not clear when, if ever, the other nine staff had done this training and it was planned for them to do it in February 2016.

A 'Safeguarding File' on the desk in the residential unit was full of very detailed information. Staff had been asked to read this and sign to confirm they had read it. There was too much information which was presented in a way that was not easy to understand and was not appropriate in supporting care staff to understand safeguarding as it related to them in their day to day work.

Incidents that had occurred within the service had not been reported to the local authority as safeguarding concerns. For example, in late 2015, three incidents had occurred where people had been at risk of potential abuse or actual abuse. The recording forms stated that no investigation into these incidents was required or had been carried out, nor had they been reported to safeguarding or CQC.

We looked at the archived records for the person involved and found no evidence that a risk assessment had been carried out and there was no plan in place to protect them or other people using the service, or to try and prevent future incidents from occurring. This meant that people had been at risk from abuse and the home had not taken appropriate action to protect them.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment.

We were informed that, after our visit on 10 December 2015, these issues were discussed with a member of the local authority's quality assurance team and appropriate notifications were made.

We looked at a selection of accident /incident reports that were dated October 2015 and were filed in the manager's office. Eight incidents had been recorded on a summary sheet but only one of these records had the person's name on. This meant that it was not evident whether the same individual or individuals were having accidents. They recorded a variety of incidents of concern.

We saw a report of an incident between two people using the service where a physical assault had taken place. The reporting form stated no investigation had been carried out and the incident had not been reported to the local authority or to CQC.

Two reports were made for a person having a short stay at Meadowcroft during October 2015. Both were for falls which resulted in hospital treatment. We looked at the person's archived records and could find no evidence that, following the first fall, the risk of further falls had been assessed and steps taken to minimise future risks.

We found evidence of other falls that had not been risk assessed or investigated properly. We did not see any evidence that staff had considered the use of assistive technology such as alert mats, bed sensors or room sensors to aid with reducing risk.

This meant that people were at risk from harm and were not protected.

There were risk assessments in the care plans we looked at, however these lacked detail and were not accompanied by plans for minimising the risk identified. For example, one person's care notes had a section for recording 'high risks'. This stated 'bathroom locks'. Nowhere within the care notes was there a more detailed assessment, explanation or guidance to show what the risk was and how it might be minimised. We checked the person's bedroom and there was an internal lock on the door of the en-suite toilet, which may have been difficult for the person to manoeuvre.

These are breaches of Regulation 12 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment

During our visit on 10 December 2015 we looked at medicines storage and recording. The medicines room was locked and the keys were with the senior care worker on duty. The room was clean and tidy. The temperature of the room and the drugs fridge were checked daily and recorded. So far in December 2015 the room was always 25 degrees or lower, however the fridge was recorded as above eight degrees on seven out of the ten days. This meant that medication which required cold storage was not stored safely. We did not see any evidence that action had been taken to address this.

Inadequate

Is the service safe?

At our last inspection we saw that nine medication errors had been identified and reported by staff during April 2015. We did not find any records of an investigation or what action had been taken. During this inspection we saw that two medication errors had been reported in November 2015, five in October 2015, and five in September 2015. The logs for June, July and August 2015 were not filed with these and we did not see them.

We also saw an incident report form dated 25/10/15 titled 'medication' which recorded four medication errors. This appeared to show a total of nine errors during October 2015. This is a very high number and suggests that people did not always receive their prescribed medication and that people's medicines were not well managed. We did not see any evidence that the reason/s for such a high number of errors had been investigated or any professional pharmacy support sought.

For one person we found two open bottles of eye drops in the fridge. Both stated 'administer to both eyes'. Neither box was dated when opened. One had been dispensed on 12 November 2015 and the other on 14 September 2015. The advice leaflet stated 'store at room temperature'. Eye drops for another person were stored in the fridge although the instruction leaflet stated 'store below 25 degrees'. These had been dispensed on 13 August 2015 but no open date was recorded. We also noted that these eye drops were not on the person's medication administration record (MAR) sheet. It is important that the open date is recorded as eye drops that contain a preservative should be thrown away four weeks after opening, and most of those that don't should be thrown away one week after opening.

In the care files we looked at we found that for one person, week commencing 30/11/15, a weekly medication audit recorded that for Sodium Valproate 200mg there should be 236 tablets left but were only 232; Sertraline 50mg should have had nine tablets left but there were only seven; Omeprazole 20mgs should have had five left but there were only four, and Sertraline 100mg should have had five left but there were only four.

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment.

The service employed six senior care staff and 16 care staff to work in the residential service. The manager told us they were 70 hours per week short of staff and were actively recruiting. Recruitment open days were being held in January 2016. They were currently using staff from a recruitment agency with the potential for these staff to become employees**.** The manager told us he asked for the same staff from the agency in order to provide continuity of service for people living /staying at the home. We saw a file containing information about the agency staff who worked at the home, including their experience and qualifications. This is good practice as it helps the manager to make a decision as to whether they are suitable to support the people living there**.**

There was always a senior on duty. They worked a three shift rota 9am to 4:30pm, 4pm to 10pm and 9:30pm to 9:30am with half an hour hand-over time between shifts. The senior staff also provided on call support for the home support service. There were three care staff on duty between 8am and 8pm and two at night. It was not clear why senior staff shifts were different from care staff shifts or why the care staff were not included in the handovers to ensure they were aware of any changes. On 29 December 2015, the new Chief Executive of the organisation told us that this was going to be addressed in the near future.

We looked at the recruitment records for two new members of staff who had been employed to work in the service since our inspection in May 2015. Their files contained a job application, interview record, two references, a record of the Disclosure and Baring Service (DBS) disclosure number, and other relevant information. This meant that the required checks had been carried out to confirm they were of good character.

During our visit in May 2015, we had concerns regarding a fire door on the residential unit which opened out into the garden. This was linked to the alarm system but sounded in a different part of the building which was only occupied during office hours. This meant that staff may not be aware that someone had gone outside during the evening or night. This had been rectified, however we noticed that the fire escape route outside this door was blocked off due to work being carried out in the kitchen. Personal emergency evacuation plans had been put in place to provide information about people's evacuation needs in case of an emergency.

Up to date service and maintenance certificates were in place for electrical installations, gas, Legionella, fire extinguishers, call bell system, and moving and handling equipment. Portable appliance testing had been carried

Inadequate

Is the service safe?

out in November 2014 and a contract for waste disposal was in place. The fire log book recorded a weekly alarm test from May 2015 to date. A fire drill had been held on 23 July 2015 and recorded four to five minutes for evacuation of the building, however it did not record the number or names of the staff who were involved or how many people were present in the building at the time.

A fire risk assessment had been written 27 March 2015 by internal members of staff. The Chief Executive said he would check whether these were 'suitably qualified' people to conduct a fire risk assessment, and if not, he would commission a fire risk assessment.

A housekeeper was on duty every day and we found the premises to be clean. Disposable gloves and aprons and antibacterial hand gels were available in the residential unit.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Providers are required to submit applications to a 'Supervisory Body' if they assess a person as needing the protection of a DoLS. A recent legal ruling stated that if a person, lacks capacity, is unable to leave unsupervised, and is under constant supervision then a DoLS should be considered.

When we inspected the service in May 2015, we saw that mental capacity was not included in the Age UK Wirral training programme and people who were supported by the service did not have capacity assessments in their care plans. This meant there was no guidance for staff about people's ability to make their own decisions and how this affected the support they required.

Meadowcroft provides a service for people living with dementia. It is therefore likely that a number of people using the service would benefit from the legal protection a DoLS would provide for them.

We looked at a document that recorded how many people had stayed at the home between 1 September 2015 and 30 November 2015. This recorded that 38 people had used the service during that time and of these four people were living there permanently.

We asked the registered manager if DoLS had been applied for with respect to any of the people living at or staying at the home and were initially told that they had been. We looked at care files for two of the people living at the service and saw that they contained printed DoLS application forms, however these had not been completed.

We asked the registered manager for evidence that DoLS applications had been made for people living at or using the service and he told us that applications had not been made consistently. We asked on three occasions to see evidence that a DoLS application had been made for any of the people who had lived or stayed at the home in the past two months. None was produced.

We asked the registered manger if he could advise us of who, if anybody, living or staying at the home had a DoLS in place. He told us that he did not have this information. We saw no evidence that a DoLS application had been made on behalf of any of the people living or staying at the home. This meant that people's rights to have legal safeguards put into place to ensure they were not being detained illegally had not been met.

We were informed that, following our visit on 10 December 2015, DoLS applications had been made to the local authority for the people currently receiving a service. A meeting had been held with the local authority and a further meeting was planned to discuss a way forward with respect to DoLS applications for people having a short stay at the service.

At our last inspection of the home in May 2015 we found that the home had not carried out assessments of people's capacity to make, or consent to, important decisions including whether they had the capacity to consent to live or stay at the home. At this inspection we found that a document to assess people's capacity to make decisions had been included within their care plans.

We looked at two of these documents for people living at the home. One stated that the decision to be made was 'long term residential'. The assessment had not been fully completed; no information was recorded for why the person lacked capacity; there was no record of what information had been given to the person or whether they could retain the information. An assessment for the second person for a decision regarding 'long term residential' was also not fully completed or dated.

The lack of completed assessments to assess people's capacity to agree to living or staying at the home means that care and treatment provided to the person may not be being provided with the consent of the relevant person.

Neither of these care plans contained any information or guidance for staff regarding the decisions the person could or could not make and how to support them to do so. Both

Is the service effective?

care plans contained a sheet signed by the person's relative giving consent for staff to give the person medication. They also contained a sheet signed by relatives giving consent for the person to have their photograph taken. Whilst a relative can agree to aspects of the person's care they cannot legally give consent on behalf of the person unless they have power of attorney for the health and welfare of that person.

During our visit on 10 December 2015, we observed a member of staff asking a relative to sign a 'consent to medication' record and to sign their agreement to the person's care plan. We observed that the relative agreed to sign but said they would like to read the documents first. It was concerning that the relative was asked to sign their agreement to care records without staff discussing the contents with them and offering them the opportunity to read them.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good governance.

We looked at staff training and supervision records. The training matrix had been simplified since our last inspection so that it showed only the names of the staff employed to provide regulated activities. This was six senior care staff and 16 care staff for the residential unit and five care staff for the home support service. Records showed that all staff had been enrolled on the Age UK Care Certificate and were working through the programme.

All except the two newest staff had completed training about Deprivation of Liberty Safeguards within the last year. Half of the staff team had not done First Aid training but were scheduled to do this in February 2016. Six staff had not done fire safety training and this was scheduled for January 2016. All except three staff had done moving and handling training during 2015.

We asked three members of the care team about what training they had relating to supporting people with dementia. One said they had significant experience of working with people with dementia, another said they had "done something" a few years ago with a past employer, and the third was a new member of staff who had no specific training in supporting people living with dementia.so far.

Records pertaining to two new care staff showed that they had completed an induction process. We spoke with one of these staff who confirmed they had an induction and shadowed another member of staff for a period of time until they felt confident to work on their own.

During our visit on 29 December 2015 we were informed that two training days had been booked with Skills for Care for the senior staff. We saw that a system of regular supervision and annual performance review had been put in place which involved senior care staff in conducting supervision meetings.

People we spoke with said "The food has been good, first class." and "It's alright." People living or staying at the home had no dining facilities other than the large dining room that formed part of the day service. We were told that people ate the majority of their meals in this dining room though supper was sometimes served in the smaller lounge within the residential unit.

We observed lunch in the dining room. Tables were nicely laid and people had access to drinks and condiments. The dining room contained seven tables each with room for four people. We noticed that several of the people who lived at the home sat near to the kitchen hatch. This meant that while they were waiting for their meal, staff were passing by constantly to serve others and at one point a member of staff leant on the back of someone's chair to talk to somebody else.

The dining experience had the appearance of a restaurant rather than somebody's home.

A menu was on display and we saw that staff supported people to eat their meal when needed. We looked at records of meals and menus and saw that people had been offered a choice and their choices had been accommodated. We also spoke with kitchen staff who had a clear knowledge of any dietary requirements people had and were able to explain how these were met.

We observed a member of staff supporting one person to eat their meal. We were impressed with the quiet, patient manner in which this support was provided. The member of staff anticipated the person's needs, changed crockery for them to make the meal easier to eat and provided reassurance and support to the person to ensure they ate their meal.

Inadequate

Is the service effective?

A light meal was served in the evening and people had a choice of a hot or a cold meal. People also had supper which included sandwiches and cakes.

The residential unit occupied an L-shaped part of the ground floor of a large two-storey building. It had 13 bedrooms and two bathrooms. Each bedroom had en-suite toilet and wash basin. There was a lockable drawer in each room and a TV. There was a call point in each bedroom and in the en-suite.

In the bedroom of a person who lived at Meadowcroft, we noticed a suitcase stored on top of the wardrobe which did not give the impression of it being the person's home. A relative we spoke with felt that the wardrobe was very small and they had asked if they could bring a clothes rail from home. They had been told that this would not be safe, however we saw that the wardrobe already in the room was not safe as it was not attached to the wall. When we discussed this with the management team we were told that additional wardrobes were available and a risk assessment would be carried out to decide whether a clothes rail could be used. When we visited on 29 December we were informed that wardrobes had all been secured to a wall.

Bedroom doors were painted in different colours to help people find their room, however signage and lighting were poor and pictures were hung too high on the walls, and in some cases were too busy, to enable them to have meaning for people using the service. There was a 'nurses station' in the middle of the unit with a large white-board on the wall along with many notices, a filing cabinet and a large desk. This did not promote a homely environment.

There was a sitting room on the unit that could accommodate ten people, but other communal space was in the part of the building that was used seven days a week for day care. The sitting room was rather dark and had no external views. When we visited on 29 December 2015 we were shown building plans to extend the residential unit into part of the day care centre which was little used. This would provide lounge and dining space and access to the garden and would give the residential unit its own identity away from the day centre.

Requires improvement

Is the service caring?

Our findings

People we spoke with were very happy with the service provided. The relatives of a person who was having a short stay told us "It has been absolutely fantastic, we couldn't ask for anything better." Another relative said "Fantastic, fabulous, outstanding staff, so caring." A relative of a person who lived at Meadowcroft said "Nothing is too much trouble, staff are so good to him. I'm here every day and I've seen nothing but kindness here, they all seem to work with a glad heart, I have a great relationship with them. There are always plenty of care staff. I only come after day people have gone home. They work hard and never leave anyone on their own. It has been a steep learning curve to them to look after people longer term. The heart of this place is a good one."

A visitor said that staff had supported their relative to keep in touch with them via the computer. Staff had always been there to support the person to use the computer and had always made sure they were available at the right time.

People who used the service told us "It's lovely. I've got my own shower and toilet."; "Lovely people" (relating to staff); "It's home from home."; "Good, I get all the attention." and "They are good, the people, if they aren't I tell them."

A number of the people who used the short stay service also attended the day centre regularly and/or received a home support service. This meant that they were already familiar with the building and with some members of staff. Family members we spoke with found this reassuring.

Interactions we observed between staff and people who used the service were positive and respectful. Staff did not wear uniforms which contributed to a friendly and informal atmosphere.

We found that the language used to describe the service, for example 'nurses station', 'respite unit', 'secure unit' needed to be reconsidered, and the use of the term 'guest' was not appropriate when this was the person's home. When we visited on 29 December 2015 this was already in progress.

When we visited on 10 December 2015 we saw that personal information was being displayed on people's bedroom doors. This was part of a project to record important information about individuals and their life histories, which was commendable, however confidentiality had not been considered in the way that this was displayed and who the person might choose to share it with. This had been removed when we went back on 29 December 2015.

On several occasions we noticed that the staff 'station' had no staff sitting at it, but daily records which recorded some very personal information about people were available on the desk. This was an open area that visitors, people who used the service, and staff who did not need to know the information walked past.

The organisation provided a range of information leaflets which gave details of the services available, including prices, and details of how to contact the 'Advocacy in Wirral' organisation.

Requires improvement

Is the service responsive?

Our findings

A relative told us they had confidence that the staff team supported their relative with their health needs. They said she was weighed regularly and staff were observant of any changes to the person's health. Another relative told us that staff kept them fully informed of any changes to their relative's health and wellbeing. One person said "The level of care is excellent. They have gone out of their way." Another person considered "The carer aspect is excellent. Communication is not always good."

Care staff we spoke with clearly knew people really well and were able to tell us in detail about people's needs and preferences and how they supported people. In one of the care files we looked at we saw a 'person centred plan' that had been written by a person's family and provided excellent information which would help the staff to know and understand the individual, however the document was mis-named as it was information and not a 'plan'.

Care files were very difficult to follow with no discernible methodology to the order of content and it was not easy to locate information within them. They contained a large number of documents but these did not all provide useful information for staff. A number of the assessment documents were checklists which did not reflect the person's individual support needs or how these might fluctuate.

Assessments of people's needs were superficial and lacked detailed information, for example one of the criteria on the 'Initial Care Assessment' form was 'Behavioural'. This gave the member of staff carrying out the assessment a choice of 'no problems', 'abusive' or 'aggressive'.

Some of the information in the care files was inaccurate, for example in one of the files we looked at, the manual handling screening tool completed on 9 December 2015 recorded that the person weighed above eight stone. However we saw in their file that their weight was recorded the next day as significantly lower than this. One person's weight on arrival was recorded as 7 stones with instruction to weigh the person weekly, 12 days later no further weight had been recorded.

Guidance within care plans was brief and not always clear. For example one person's care plan stated 'needs assistance of two carers' for personal care, but it gave no detail what this assistance was or how it was to be provided.

These examples are a breach of Regulation 12(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment

CQC had received a complaint from a member of staff working at the service who was concerned about moving and handling practices and believed that staff and a person who used the service were at risk. During our visit on 29 December 2015 we observed three members of staff attempting to move a person using a handling belt. This procedure was unsuccessful and unsafe. The staff eventually agreed to sit the person back in their wheelchair and use the hoist.

We looked at the person's care notes which recorded '2 carers to assist as mobility poor - have use of a hoist'. This conflicted with the care practice that we had observed which placed the person at considerable risk. We saw that a generic assessment was in place for using the handling belt but there was no specific guidance for supporting the person.

We found advice in the person's file from both an occupational therapist and a physiotherapist. This had not been carried through, and that staff did not really have an understanding of the mobility of the person. We spoke with the person who told us "Staff are very kind to me, I have no complaints. I don't mind the hoist."

One person was receiving a service from district nurses to treat a skin break. The district nurses had supplied an airflow mattress and seat cushion to help reduce the risk of further deterioration. A member of care staff told us "We have to reposition him when he's in bed . The district nurse came out yesterday, we need to reposition him each hour at least." We could find no repositioning chart in place.

These examples are breaches of Regulation 12 (2) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment

Two relatives told us they were pleased with the range of activities people could participate in. They felt this kept

Requires improvement

Is the service responsive?

people stimulated and active. A relative told us staff had supported their relative to go out for a cup of coffee and shopping. They had also supported people to go to a local pantomime.

We observed that the atmosphere in the day service was cheerful, lively and engaging. People were able to join in a range of activities and staff spent time encouraging people to do so. Activities included quizzes, dominos, pool, table football, music, colouring and CDs. We saw that people could spend their time in smaller groups, in a larger group activity or in a games room as they preferred.

We were advised by senior staff that people living or staying at the home could choose where to spend their time. They explained the day service was open seven days a week from approximately 9am to 4.30pm although people started to leave at 3pm. They said the people living and staying at the home usually went through to the small lounge in the residential unit when other people left the day centre as they could become distressed when they did not go home. They then had to return to the large dining room and usually spent their time in the large day centre lounge before going to bed.

On both of days of our inspection we saw that one person chose to stay in the care home during the morning. Other than that we saw no evidence that people were encouraged or supported to spend some of their time in their home and there appeared to be an expectation that people spent their waking hours in the day centre.

We looked at the complaints procedure which was included in the information leaflet. It was easy to understand and gave people details about who they could contact if they wished to make a comment or a complaint. During our visit in May 2015 we were told that complaints were dealt with by the Chief Executive and records were kept at the organisation's head office in Birkenhead. When we visited the service in December 2015, a complaints file had been put in place at Meadowcroft and contained detailed records relating to three complaints that had been received and how they had been responded to.

Inadequate

Is the service well-led?

Our findings

We asked a care assistant who they would go to if they had any concerns and they told us "First the senior, if not the managers, all are approachable." People who had a short stay were invited to complete a feedback form 'Are we getting it right?' and we found that people who used the service and their families had given very positive feedback.

We were concerned that the manager had other responsibilities in addition to being registered manager for the residential and the home support services. There was no deputy manager. The manager's office was at the opposite side of the building to the residential unit which meant that he was not a visible presence for people who used the service, staff or visitors so that people could approach him with day to day matters, nor could he directly observe the service provided.

We were concerned about an apparent lack of awareness of issues we found relating to choice and confidentiality and the failure to provide a homely environment for people who had chosen to live at Meadowcroft.

On both of our previous inspections we had concerns with the way that the quality of the service was assessed and monitored. During this inspection we saw that there were some quality audits in place, however they did not fully identify and address potential risks to people's health, safety and welfare. For example, the accident and incident audit did not identify what action had been taken to address safety issues reported; a significant number of medication errors continued to occur with no effective action apparent; mental capacity assessments were not completed and DoLS were not applied for; care plans were not written to provide clear and accurate guidance for staff.

Since our last inspection, additional administration support had been provided and we saw that some of the management records were presented in a more tidy and orderly manner. During the first day of this inspection, information could not always be located quickly if at all, for example DoLS records. Incidents of concern had not been reported to the local authority or CQC.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good governance.

At the end of the visit on 10 December 2015 we shared our concerns with the manager and the provider and immediate action was taken. When we returned to the home on 29 December 2015 we found that a reorganisation of management arrangements was being implemented with new job descriptions and plans for seven day a week management presence within the residential unit.

Plans had been drawn up to create an office for the manager in the residential unit and to increase the amount of living space available exclusively for people using the service. We found that the new Chief Executive Officer had an understanding of the way in which CQC inspect and how to plan quality assurance tools. He expressed his commitment to improving the service and we saw that a number of improvements had been made and firm plans had been put in place since the first day of inspection including arrangements for further training, seeking professional advice, architect plans, and management support.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's health and welfare risks had not been properly assessed or mitigated against in the planning and delivery of care Medicines were not always managed in a proper or safe way. Regulation 12(1) and 12(2)(a)(b)(g)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment There were no established systems in place to effectively record, investigate, act upon, prevent and report any allegations of abuse in order to protect people from potential harm. Regulation 13(1)(2)(3)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider did not have effective systems in place to assess and monitor their service against Health and Social Care Act Regulations or to assess, monitor and mitigate the risks to the health, safety and welfare of people who used the service.

Regulation 17(1),(2)(a)(b)(c)

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.