Shamrock Villas Limited

Meadow View

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on the 16 and 19 of April 2018.

Meadow View is a residential care home providing accommodation and personal care for up to four people with mental health conditions. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection, four people were using the service. The service is provided from a single, two storey domestic dwelling.

We previously inspected Meadow View in July 2017 where the service was given an overall rating of Requires Improvement as we found the registered provider to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Shortfalls included, ineffective systems for monitoring the quality and safety of the service, insufficient numbers of suitably qualified staff, a failure to ensure people's consent to care and treatment was obtained and their capacity to make decisions appropriately assessed in accordance with the Mental Capacity Act (2005). The provider did not ensure that person's employed were recruited safely and trained appropriately to meet the needs of the people who used the service.

At this inspection we found a deterioration in the management of people's safety and welfare. We found a continued breach of Regulations 11, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Oversight and management of the service was chaotic and disorganised. There continued to be insufficient governance arrangements in the service and therefore was still not effective in mitigating the risks to people's health, welfare and safety.

We found the registered provider had failed to address all the issues raised at the previous inspection. There had been deterioration in the quality of care in other areas, which meant the provider was also in breach of other Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks.
There was a lack of a clear vison and credible strategy to deliver high quality care and support, and promote a positive culture that is person centred, open, inclusive, empowering, which achieves good outcomes for people.

Immediately following our inspection, we formally notified the provider of our escalating and significant concerns and our decision under Section 31 of the Health and Social Care Act 2008, to impose conditions on their registration as a service provider in respect of the regulated activity. This included placing conditions on their registration with immediate effect to restrict further admissions to the service. The commission is further considering its enforcement powers.

We requested the provider to tell us by the 23 April 2018 what actions they would take to mitigate the risks

we identified at this inspection. For example, in relation to the immediate risks of scalding from un-covered radiators, exposed hot water pipes, un-restricted windows, staff training and competency assessments. We found shortfalls in relation to their ability to safely meet service users' specific physical and mental health needs, substance misuse and safe moving and handling. We also requested evidence of action taken to ensure dependency assessments were carried out with appropriate numbers of staff available at all times to meet people's needs. Other conditions included a request for written evidence of action taken to ensure a robust system in place for regular maintenance of the premises.

The service had a registered manager who is also the registered provider and who was also registered as manager at their other service. 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.

The service was not operating in line with its statement of purpose and information they claimed on a public website.

There continued to be a lack of systems in place to ensure effective oversight and governance of the service. The provider did not demonstrate they had systems in place to continuously learn from incidents, improve, innovate and ensure sustainability. Quality and safety monitoring systems had failed to identify the issues we found during our inspection.

People were not cared for in a clean, hygienic or well-maintained environment. The provider had not identified a number of infection control issues in checks and audits. They had failed to take the necessary actions to ensure that the risks to the health and safety of people were assessed, mitigated and reviewed appropriately.

Suitable procedures were not fully in place in regard to the administration and recording of medication.

There were not always enough staff to meet people's needs and provide them with support at the time they needed it. The provider continued not to practice safe recruitment procedures. Staff started working at the service before appropriate safety checks had been carried out. This left people at risk of receiving care from staff who were not suitable.

Staff received training. However, we identified a number of concerns regarding the care and support provided throughout our inspection. This meant we could not be confident that the training provided was effective, took into account best practice, and was imbedded in staff practice.

People's care had not been co-ordinated or managed to ensure their specific needs were being met. People were not adequately protected against environmental risks. People's medicines were not always managed effectively to protect them from the risks of not receiving prescribed medicines.

Care records did not demonstrate how people received personalised care that was responsive to their needs. Despite the intentions of the provider to provide a rehabilitation service, there were no rehabilitation plans in place to demonstrate what skills people needed to develop in order to move to a more independent living with a plan of people's life goals. Plans of care used negative language and sought to impose how people should behave and what they should do.

The registered manager and staff continued to demonstrate a lack of understanding regarding the Mental

Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Systems in place to reduce people being at risk of potential abuse were not robust. Staff did not recognise or understand the wider aspects of safeguarding people from the risks as identified in this report. Staff did not always use language which was respectful. The provider had not ensured the service was being run in a manner that promoted a caring and person centred culture.

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

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

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

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.

Risks were not identified for all areas. Risks were not suitably monitored, managed or mitigated so as to ensure people's safety and wellbeing.

There was a lack of systems in place to ensure sufficient numbers of suitable staff to support people to stay safe and meet their needs.

Suitable procedures were not fully in place in regard to the administration and recording of medication and responding to medicines errors.

Staff did not know how to report any suspicion of abuse to the relevant safeguarding authorities and were not aware of whistle blowing policy or procedures.

People were not cared for in a clean, hygienic or well-maintained environment.

Is the service effective?

Inadequate

The service continued not to be effective.

Training was not sufficient to provide staff with the skills and knowledge they needed to meet people's care and treatment needs and keep them and others safe.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Care and support was not provided in line with current legislation, standards and evidence based guidance.

People were not always effectively supported with their nutritional needs.

People did not always have planned access to appropriate services to ensure they received ongoing healthcare support.

Is the service caring?

Inadequate

The service was not consistently caring.

Whilst care staff demonstrated some kindness in their interactions with people living at the service, the registered provider had not ensured the service was being run in a manner that promoted a caring and person centred culture.

People were not always involved in making decisions about their care.

Plans of care used negative, judgemental and derogatory language in describing people and their behaviours.

Is the service responsive?

Inadequate

The service was not responsive.

Care records did not provide sufficient guidance to staff to help ensure the care provided was safe, effective, personalised and responsive to their needs.

Despite the intentions of the provider for Meadow View to be a rehabilitation service, there were no rehabilitation plans in place.

The registered provider failed to operate a system to use people's views in planning to improve the quality of care.

Is the service well-led?

Inadequate

The service continued not to be well led.

There continued to be a lack of systems in place to ensure effective oversight and governance of the service. The provider did not demonstrate they had systems in place to continuously learn from incidents, improve, innovate and ensure sustainability.

The poor oversight and lack of leadership had resulted in a lack of structure and direction for the staff team.

The conduct and demeanour of the registered manager who is also the registered provider, whilst carrying out their role did not promote a positive culture in the service.

Meadow View

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.

We carried out this unannounced comprehensive inspection on the 16 and 19 of April 2018. The inspection team consisted of two inspectors.

Prior to the inspection, we reviewed information we had received about the service such as notifications. This is information about important events, which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority quality monitoring team.

During the inspection, we spoke to four people who used the service. Some people could not tell us their views about the care and support they received, as they were unable to communicate with us verbally, therefore we spent time observing interactions between people and the staff who were supporting them. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with four people who used the service. We also spoke with the registered provider, deputy manager and two support workers. We observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care and support needs were being met we reviewed the care records of all four people who used the service including risk assessments, management of their medicines and monitoring charts in relation to care support provided. We also looked at health and safety management, staff recruitment files, staff training records and systems for assessing and monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

At our inspection of the service in July 2017 we found significant shortfalls in the provider's understanding of their roles and responsibilities in relation to the mental capacity Act 2005. We rated the service 'Requires Improvement' in 'Safe'. At this inspection we found deterioration in the management of people's safety and welfare and judged the rating as 'Inadequate'.

Staff told us they had received training in safeguarding people from the risk of abuse and were able to identify some types of abuse. However, they did not recognise or understand the wider aspects of safeguarding people from the risks we identified at this inspection or the impact of neglect from not having enough staff to meet people's needs and the environmental risks. The breaches in this section demonstrate that people were not being safeguarded from the operation of the service overall.
We were not assured the registered provider was doing all that was reasonably practicable to mitigate risks to people's safety. This included ensuring that the premises are safe to use for its intended purpose and risks associated with the risk of fire, cross infection and security considered.

External companies had been contracted to carry out regular checks on the fire system. Regular testing of the fire alarm system and firefighting equipment and emergency lighting was taking place. Routine fire drills were taking place and feedback provided to staff. The fire risk assessment contained information about control measures in place to reduce the risk of harm from fire; however, staff were not following these. For example, the assessment stated 'fire doors to be free of obstruction, i.e. door wedges.' We found door wedges in use to hold doors open throughout the premises including the kitchen a high risk area. This practice placed people living and working at the service at risk of harm from smoke inhalation and burns, as the wedged open doors would not prevent fire spreading through the premises.

Additionally, we found risk assessments in place for all four people using the service in relation to smoking in their rooms. These had not adequately assessed the risks to people. Each person had signed a letter to say they would not smoke in their rooms and consenting to room checks for flammable items. The minutes of staff meetings and records of the weekly checks showed people continued to smoke or harbour flammable items. Records showed there had been five occasions in a twelve-week period, where lighters, lighter fluid and cigarettes had been found and removed. Other than speaking to people, there had been no further consideration of finding alternative ways of controlling or mitigating the risk of fire occurring due to people smoking in their room.

The fire assessment also referred to all electrical equipment to be checked using a Portable Appliances Test (PAT) to ensure they were safe to use. We found none of the appliances had been tested. We discussed this with the provider who told us on day two of our visit they had purchased a PAT tester and an electrician was starting to test all appliances.

People have had Individual Personal Emergency Evacuation Plans (PEEP) completed to assess their ability to leave the building in the event of an emergency. These assessments all contained the same information and did not accurately assess the individual risks. For example, one person's PEEP had not been updated to

reflect deterioration in their mobility and mental health. The deputy manager told us, the person now needed staff support to mobilise, but their PEEP stated they were able to evacuate independently.

People were not protected against other environmental risks. Systems for assessing risks to people from falling from un-restricted windows and sustaining burns from unprotected surfaces and hot water pipes were not effective. There was a lack of systems for health and safety auditing including a lack of process for checking windows to ensure they are safe and in good working order.

One person's windows were locked shut, with no key available. Risk assessments were not robust to identify and ensure action was taken to mitigate risks to people from locked or unrestricted windows.

Another person's risk assessment completed on 25 July 2017 was ticked 'yes' to having window restrictors in good condition and only operable with a special tool or key. However, we found there were no window restrictors fitted to any of the rooms on first floor windows. One person's room had two large windows, which opened wide with a significant drop to the ground outside. The same person's risk assessment had also identified risks of burns and scalds from hot water, radiators and exposed hot water pipes. The assessment had identified radiators were not low surface temperature and not covered, however, the assessment had been ticked as 'no' for additional control measures needed to reduce the risk. There was no additional information to demonstrate that the provider had taken all reasonable steps to ensure the health and safety of people using the service and prevent the risk of avoidable harm. For example, one person had poor mobility and was at risk of falls. They had an un-protected radiator and hot water pipes in their room. At night there was only one sleep in staff. If the person fell at night against the radiator and or hot pipes feeding the radiator, they had no means of calling for assistance as there was no call system in place. This placed the person at significant risk of harm.

The service had a policy and procedure for the administration of medicines. Staff responsible for the administration of people's medicines did not do so in line with the provider's policy and procedural guidance. This stated that 'any changes in prescribed medicines should only be provided by the GP or supplying pharmacy in written form. Verbal instructions should not be accepted'. However, we found the deputy manager had altered one person's dose of medicine on their medication administration record (MAR) as well as written changes on the pharmacy label on the bottle of medicine.

There was a lack of robust profiles produced, which would describe the medicines prescribed for each person, the reasons for this and how people liked to take their medicines. Some people were prescribed medicines to be administered 'as and when required' (PRN) when they became anxious and distressed. Best practice guidance suggests that these should only be administered after staff have first supported people with positive interventions and strategies to avoid the use of medicines being given unnecessarily. PRN protocols in place contained limited information to guide staff regarding the use of these interventions. We saw for one person daily records which evidenced their PRN medicine had been administered in the first instance without for example, positive verbal de-escalation methods.

We carried out an audit of stock against MAR records. We found that not all medicines tallied. We were able to ascertain that this was as a result of incorrect carried forward totals from one month to the next. Whilst we were told regular medicines audits took place, this shortfall had not been identified by the deputy manager's audits.

Staff received medicines management training from the supplying pharmacy. However, there was no system in place to ensure their competence to administer people's medicines safely had been regularly assessed. This did not assure us that the registered provider had systems in place to ensure the proper and safe

management of people's medicines.

There was a failure to take opportunities for learning from incidents to help improvement. Accidents and incidents were not consistently recorded and analysed by the registered manager. These and other practices were not regularly reviewed to ensure learning could be applied to make future recurrences less likely. This included a lack of systems in place to respond to and investigate medicines errors. We noted from a review of staff meeting minutes that one person had been administered a double dose of their night time medicines. We discussed this with the deputy manager. They told us that following this incident no attempt had been made to contact the person's GP for professional clinical advice and neither had the incident been formally investigated with outcomes and actions explored to prevent a reoccurrence.

The shortfalls in the management of risks were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safe care and treatment

There was a lack of systems in place to assess, review and ensure sufficient numbers of suitable staff to support people to stay safe and meet their needs.

The deputy manager told us that they were short of staff on the day of our inspection and they were the only one on duty and the following day. The deputy manager confirmed that the rota for the week beginning 12 April 2018 did not accurately reflect the actual staff on duty for the 16 and 17 April 2018. This meant there was only one member of staff on duty. Whilst they told us, the needs of one person had increased and they now required two staff this was not always reflected in the numbers of staff allocated. There was no system in place for assessing the dependency needs of people and so were unable to assure us that people's welfare and safety needs were being met with planning to ensure sufficient numbers of staff were available at all times.

The registered provider confirmed they had not carried out a review of staffing levels to ensure there were sufficient staff available to meet people's assessed needs and keep the home clean. They were unable to demonstrate how staffing numbers had been calculated to ensure sufficient numbers of staff were available day and night to meet people's welfare and safety needs.
One person had deteriorating physical and mental health needs, their daily records showed us that they sought support from staff during the night time period and were at risk of falls. The registered manager told us the needs of this person had deteriorated but they had failed to carry out any formal dependency assessment of their needs to determine the number of staff required to support them safely during the day and night. This person and others did not have access to a call system to raise the alarm in the event of an emergency or the ability to call for support during the night time period from the one available sleeping-in member of staff. Sleeping-in staff were located at night in a room two floors up from this person. Immediately following our inspection we requested the provider take urgent steps to mitigate these risks. They told us that in response to our concerns sleep-in staff now slept on the ground floor of the premises. However, their response did not fully assure us that the staff required to meet people's needs during the night time had been fully addressed, and the risks mitigated.

This demonstrates a continued breach - Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing

Recruitment practices were not robust. At our last inspection we found staff employed prior to any appropriate checks carried out through the Disclosure and Barring Service (DBS) for the majority of staff employed. Since our last inspection only one member of staff had been employed. Whilst a DBS check had been carried out there was no reference requested from the most recent employer as required. When asked

why not the provider said, "They [recent employer and staff member employed] don't like each other so there was no point." There was no system in place to evidence their decision making to go ahead and employ. We also found there was no evidence of interview questions asked with responses and so we were not assured that the provider had recruitment procedures established and operated effectively to ensure persons employed had the skills, competence and were of good character.

This demonstrated a continued breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and proper persons employed.

We found a lack of action taken to ensure people lived in a clean environment. There was a lack of infection control systems to mitigate the risk of harm to people and prevent the risk of cross contamination. Whilst staff told us it was the responsibility of people who used the service to maintain the cleanliness of their rooms and communal areas they had failed in their duty of care to support people appropriately. We found toilets and bathrooms without toilet rolls, soap, hand drying towels and waste bins.

We found the premises were in a poor state of repair and environmental risks were not being well managed. Service users' bedrooms, the stairs and landing were in a very poor state of neglect, both for furniture, fixtures, and cleanliness. The stairs leading to the first floor was very dirty and the carpet was threadbare in places. The paint on the window frame and sill at the top of stairs was peeling and showed signs of rotting wood underneath. The upstairs bathroom did not have a window blind, which showed service users' privacy and dignity had not been considered. The shower and bathroom floor tiles were cracked and the shower tray was stained and dirty around edge of the floor. This is presents a potential cross infection. One of the bathrooms was out of use and the bath did not have a plug. One of the toilets was not working because the handle to flush had broken. We discussed these shortfalls with the provider who in response instructed a plumber to replace the toilet flush handle and assured us they would attend to fixing the broken sinks in people's rooms.

We noted one person's room was very dirty around the skirting boards and on the walls, including a brown stain on the wall behind their bed. The basin in their sink was cracked.

In another person's room we found both windows, and in particular one fanlight were very dirty. One of the curtains was missing. Curtains were very thin and had no linings to block out the light. A freestanding wardrobe had not been bracketed to wall and was crammed full and at risk of falling over. The bedside cabinet was very badly stained, as was the flooring. The flooring also had large crack in the surface. The sink had been pulled away from the wall and the surrounding tiles had been removed leaving exposed plasterwork. The cold tap swivelled around and was not connected to the water supply. The deputy manager informed us the person using this room had pulled the sink away from wall, two to three months ago and was awaiting maintenance to fix it. The bed sheets were heavily soiled, stained and in need of washing and or replacement.

Yet another person's room was also found to be dirty around the skirting boards. The sheets on their bed were soiled, stained and in need of washing and or replacement. They had two pillows; but each pillowcase contained two lumpy and stained brown pillows inside.

Research by The Royal College of Psychiatrists and Mental Health Foundation concludes that services for people with complex mental health problems need to have quality and robust fixtures and fittings that meet service users' needs and promote recovery. Poor furnishings, decoration and fixtures and fittings have been shown to have a negative effect on people's mental wellbeing, hindering recovery, and aggravating existing mental illness.

There was a lack of a robust system in place to regularly assess the risk of and prevent, detect and control the spread of, infections. We looked at the provider's infection control policy and procedure and saw that this had not been reviewed since December 2010 and related to previous regulations no longer relevant. However, the policy did refer to the Code of Practice for Health and Adult Social Care on Prevention of and Control of Infections and Related Guidance. This had been signed by staff to say they had read and understood the content of the policy and procedures they should follow to prevent and control the spread of infection.

A set of cleaning and deep cleaning guidelines, reviewed May 2011, again had been signed as read and understood by staff. These guidelines differentiated between deep cleaning and routine cleaning, frequency and method of cleaning, such as vacuum carpets daily and clean floors daily. However, we found staff were not carrying out cleaning duties. Instead, staff told us that cleaning of the premises was the responsibility of people who used the service as part of developing their 'Life Skills' and therefore the poor environment was blamed on their choice. Life skills and cleaning and responsibilities care plans stated people were expected to clean their rooms and communal areas, with staff to prompt and support. However, this was not happening. We saw two people had weekly cleaning schedules on their notice boards. There had been no entry by staff to say cleaning had taken place since 19 February 2018, for one person and 15 January 2018 for the other.

There was no system for ensuring the service was maintained the required standard of cleanliness to reduce the risk of people acquiring infections. For example, we observed a member of staff's dog regularly enter the kitchen area. The microwave, oven and kitchen cupboards had not been regularly cleaned and kitchen cabinets were in need of repair. We found due to self-harming behaviours of one person toilets had no soap, towels, toilet paper and waste bins. There was no alternative arrangements explored to ensure people and their visitors had access to hand washing facilities.

There was a lack of oversight and suitable arrangements in place for the purchase, maintenance, renewal and replacement of the premises, furniture and equipment with a timely response to required maintenance issues when identified. There was no system to ensure regular maintenance of the service.

We observed on day one of our visit water pouring through a ceiling, electric light fitting in the communal lounge. The registered manager told us they were waiting for a maintenance person to be employed to fix this. However, inspectors instructed them that given the immediate, potential risk to people's safety to call for emergency support from an electrician and plumber.

The provider told us and we observed that the conservatory used by people on a daily basis had sustained significant subsidence. This presented a risk of glass becoming dislodged and put people at risk of harm. There was a lack of risk management and monitoring with actions planned with timescales to rectify this fault and ensure people lived in a safe well maintained environment.

This demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Premises and equipment

Inadequate

Is the service effective?

Our findings

At the last inspection in July 2017 this key question was rated as 'Requires Improvement' as we found the registered provider did not ensure that all staff employed received training of a sufficient standard to enable them to meet the assessed needs of people who used the service. At this inspection we have judged the rating as 'Inadequate'.

We identified a number of concerns regarding the care and support provided throughout our inspection. We checked whether the registered provider utilised current legislation, standards and evidence-based guidance to ensure they worked to current best practice in meeting the needs of people with mental health conditions. We were not assured that people received care and support from staff where the training provided was effective, took into account best practice, and was imbedded in staff practice.

The registered provider told us there was no set budget for training. They claimed within their statement of purpose and on a public website that they provided care and support to people with drug and alcohol dependency, supported people diagnosed with schizophrenia, bi- polar/depression and eating disorders. However, we noted that staff had not been provided with the required, specific training to meet these needs or had the skills and knowledge to support people and meet their needs. The provider was unable to demonstrate how staff and the management team ensured their knowledge was up to date and reflective of best practice.

The deputy manager who had the delegated task of organising staff training told us, "Someone did once come to the home to deliver training in mental health, I think it included bipolar but I don't like face to face training, I find it boring, listening to the facilitator drone on, I don't take it in and the staff agree with me."

Apart from medicines administration all other staff training was predominantly provided by watching DVD's and e-learning. It was difficult to assess how effective the e- learning had been. For example, staff had completed e-learning for infection control and food safety hygiene training, but had not identified the poor hygiene and poor practices in relation to the environment including food preparation in the kitchen. Staff had also completed training relating to the Mental Capacity Act and management of medicines but we found they lacked understanding and knowledge of good practice in both these areas.

We looked at how the service used restraint and saw that staff had not been trained in positive de-escalation and other behavioural management techniques. The registered manager told us there was no one who required physical intervention to manage behaviours, however one person's mental health assessment recorded, 'staff are unable to take [person] out in the community due to 'verbal allegations and aggressive behaviour'. Where daily records showed us that some people expressed distressed behaviours which may present a risk to themselves and others, there were no behavioural management plans in place which would guide staff as to any triggers and strategies to reduce the risk of harm to self and others.

Staff discussions and a review of records showed us some staff meetings and one to one supervision sessions had occasionally taken place but were not regularly planned and provided. Where staff had

identified in staff meetings issues in relation to the poor management of the environment these had not been addressed. We were not assured that opportunities were regularly provided to enable staff to discuss their performance, assess their competency and plan their training and development needs.

This is a continued breach - Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing

At our last inspection we found a lack of awareness and the registered manager's understanding of their roles and responsibilities in relation to The Mental Capacity Act and related Deprivation of Liberty Safeguards (DoLS).

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager and staff continued to demonstrate limited understanding of the MCA and DoLS. People were not always supported to have maximum choice and control of their lives and staff lacked understanding in how to support them in the least restrictive way possible.

Care plans did not all contain consideration of whether people had the capacity to make decisions about their health and the management of their money. No assessments had been carried out to establish if DoLS applications should be made for people living at the service. However, people's liberty was being deprived in some circumstances. One person told us, "I don't go out. I would like to. I'm not happy here."

Where interventions were in place to mitigate the risk of a people consuming alcohol on the premises, handling their own money, these were restrictive and the impact on the person's freedom not always considered. Interventions to manage risks had not been documented as being made in agreement with the person and their best interests considered.

Staff told us that whilst one person had capacity to manage their own money, it was evident their money was being managed by one member of staff without clear procedures for how this was being managed, agreed by the person and without regular audit and review.

Where people had limited or fluctuating capacity to make decisions about their everyday lives, there were no DoLS referrals submitted to the local safeguarding authority for best interest assessments by those qualified to do so. This meant people's best interests had not been explored and agreed in relation to for example, managing their finances or any other deficits in their capacity to make unwise decisions. This is a restrictive practice and without an appropriate best interests assessment impacts on the person's human rights.

In one person's care plan we found, a consent to treatment procedure form which made reference to the

previous Health and Social Care Regulations 2009. This consent to treatment had not been signed, dated or reviewed.

People subject to section 117 of the Mental Health Act 1983 places a statutory duty upon health and local authorities to provide after care including a regular review of their care to persons who have been detained under specific sections of the Act. Whilst it was the responsibility of the placing authority to ensure these reviews took place the registered provider did not assure us that they took action to advocate on behalf of people to ensure these took place.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Need for consent.

The deputy manager told us that for all but one person, people shopped and prepared their own food. We saw that people had a designated space in kitchen cupboards to store their food and weekly menu plans had been produced. However, records did not provide evidence that people were appropriately supported to maintain a balanced diet. We observed people who stayed in bed for the majority of the day with no planned encouragement or intervention to ensure people ate and drank sufficient amounts to maintain good health.

We noted and staff confirmed two people had poor appetites and were at risk of losing weight. There were no weight records maintained at the service. One person at risk of inadequate food intake had an eating plan in place and dated 2015. We found no evidence that their eating plan had been reviewed. This plan stated the person was to be encouraged to do their own shopping and cooking. This also referred staff to offer a liquid food supplement three times a day. However, there was no record to reflect when and how often this had been offered. We saw that their last GP review took place in March 2018 and their weight had been recorded at the surgery. Their care records stated 'weight taken at surgery 61kg which is really good, but [person] needs to put on weight'.

We discussed our findings with the deputy manager and asked how given people's weight had not been monitored regularly how would they know if people at risk were losing or gaining weight? They told us, "We just know by looking at them. We give them Complan [a food supplement] if we think they are not eating enough."
We noted entries in care records that people had been supported to access chiropodists, community psychiatric nurses, psychiatrists and GP's. However, there were no health passports or action plans in place to guide staff in supporting people to maintain their health and wellbeing with planning for ongoing support and treatment. We were not assured that people's care and treatment was always planned appropriately in order to meet their needs and appropriately supported to live healthier lives, with planned access to healthcare services.

We were not assured that the registered provider was consistent in their approach when people moved from one service to another and that care and support was properly planned and reviewed to meet their needs.

One person was prescribed a bi-weekly Risperidone injection, an antipsychotic medicine. There was no information in their care plan to guide staff as to any health conditions or confirmation of any formal diagnoses of their mental health condition and the reasons for which this medicine was prescribed. The deputy manager told us they did not know this information. They said this person had been admitted to the service as an emergency without any pre-admission assessment having been carried out. They also told us they had not received or chased for this information despite this person having moved to the service 12 months ago. NICE guidance states that steps should be taken to ensure that people prescribed

antipsychotic medicines have a care plan which clearly describes the rationale for the use of antipsychotic medicine, how long it should be taken for and a strategy for reviewing the prescribing of this medicine.

This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care

Inadequate

Is the service caring?

Our findings

At the last inspection in July 2017 this key question was rated as 'Requires Improvement'. At this inspection we have judged that the rating as 'Inadequate'.

We identified widespread failings in the oversight and management of the service provided, which meant that people did not always receive the care and support they required to uphold their health, dignity, safety and welfare. The management team had failed to independently identify these failings and take action to improve the quality of the care people received. This meant that the management team did not promote a culture focused on providing safe, personalised care.

Whilst we observed some positive caring interactions between people and staff, further work was needed to imbed a culture of respect and caring throughout the service. Care plans were not person centred, were punitive in nature and staff used derogatory language to describe people's refusal to engage with staff. This showed a lack of understanding and respect for the specific needs of people.

Care plans were written using negative, judgemental and derogatory language in describing people and their behaviours. People who used the service were not always involved in developing their care and support plan. Whilst we saw that people had signed their care plans they told us they had not been involved in the planning and review of them. One person told us, "They ask me to sign but I don't know what is says about me."

Staff did not always use language which was respectful. One person told us, "Some staff are always stressed. I don't like to bother them when I need my money; they tell me I am a pain." This discussion took place in the presence of the deputy manager. They told us, "Well yes I do say sometimes 'you are a pain in the butt'. We are family here; they know we don't mean it, don't you?" [Referring to the person who used the service]. The person expressed how this type of interaction had made them at times feel a loss of dignity.

We observed people coming and going from visiting the service including people carrying out plumbing and electrical work, walking into rooms where people who used the service were present. We noted a neglect to acknowledge the presence of people who used the service, talking over them. This lack of respect went unchecked by the staff and registered provider. We also observed during the two days of our inspection staff shout across people to each other without any sensitivity to how this may be perceived as lacking in respect for people. At one point the provider shouted out in front of one person sitting in the communal lounge, "Close me down, close me down now." There was no acknowledgement of how this may have impacted on the person present as this was their home.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Dignity and respect.

Inadequate

Is the service responsive?

Our findings

At the last inspection in July 2017 this key question was rated as 'Good'. At this inspection we have judged that the rating as 'Inadequate'.

The registered manager told us people were involved in the planning and review of their care. However, we did not find evidence to show this was the case. People told us they had signed care records but did not know what was in them. It was not clear if and when reviews took place, who with, and how people had been fully supported to be involved in making decisions about their care and support.

We were not assured that steps had been taken to planning care and treatment with a view to achieving people's preferences and ensuring their needs were met. Despite the intentions of the provider for Meadow View to be a rehabilitation service, there were no rehabilitation plans in place.

The registered provider's statement of purpose and information contained on a public website claimed that people were supported to access work and college opportunities. People did take part in some activities to assist in rehabilitation and independent living such as cooking meals and shopping. However, none of the people living at the service attended educational or work based activities, paid or voluntary. The deputy manager told us when referring to two people, "They just want to drink all day. They don't want to work or go to college, they are just not interested, so what do you do."

Care records did not include sufficient, specific information on how to care and support people who had diagnosed conditions such as paranoid schizophrenia, Korsakoff's dementia, alcoholism and other substance addictions. Whilst we saw varying levels of health professionals input, including mental health there was limited information as to any feedback from appointments and advice provided.

It was apparent from discussions with staff that there was a lack of knowledge in meeting people's mental health needs as staff were unaware of best practice guidance, such as NICE guidance on managing and supporting people with diagnoses of schizophrenia. Two people had a diagnosis of paranoid schizophrenia. One person staff told us also lived with chronic alcoholism. As the consumption of alcohol was banned from the service, this person spent their day drinking in a pub or stood outside local shops or in parks where children were present and had been found urinating in public. We noted staff administered their medicines but the person took responsibility for collecting their own medicines from the pharmacist. Their care plan stated staff should escort them to collect their medicines, however staff told us another person using the service took on this role. It was not clear why this change in their plan of care had taken place or if any assessment of risk had been carried out.

We noted one person with deteriorating mobility and asked the deputy manager what steps had been taken to assess their needs, for example, attempts to access advice and equipment support from occupational therapists (OT). They told us, "It's not up to us to ask for an OT, that's for the GP to do. They should notice when an OT is needed not us."

Care plans used negative language in describing people and their behaviours We found care records written in a manner which was derogatory and judgemental. One person's mental health plan stated they had a diagnosis of a particular dementia known as Korsakoffs. This presented with them being forgetful due to their short-term memory. Their care plan stated 'this is causing you to become frustrated and angry, you display very erratic mood swings, one minute you appear fine and the next you are being verbally abusive for no apparent reason'. In the risks identified section, a record had been made that, 'people are not listening to you because your attitude is not always acceptable'. This demonstrated a complete lack of understanding on managing and supporting people with their mental health needs.

Although the service was registered to provide accommodation and personal care it was apparent staff were confused as to what support they were expected within their roles and responsibilities to provide. They told us it was not their role to provide people with personal care. When discussing the needs of one person whose physical needs had deteriorated whereby they could no longer manage their personal care without support. Staff told us, "We don't provide personal care here. We only support people…we don't do things for them, although I couldn't live with myself if I didn't help [person] with a shower sometimes. They need to move on from here."
Care plans contained very limited information regarding people's life history and personal interests. There was insufficient information which would indicate that people's personal goals and aspirations had been fully explored. One person's care plan contained a quality assurance questionnaire completed with the person by a member of staff. The person had been asked if they liked living at the service, they had responded, "No I am bored. There are no other people of the same gender or age for me to speak with." They also told staff they would like to spend time with horses and had previously enjoyed hobbies such as pottery and art. In response staff had encouraged them to paint a mural on the conservatory wall. When asked what attempts had been made to support them with their love of horses, staff told us due to the person's reduced mobility they did not support them to go out. They said, "We are not allowed to use wheelchairs; we have not been trained or assessed as competent." Staff did not evidence any other options explored to enable this person to enhance their quality of life.

We were not assured that there was sufficient planning with steps taken to enhance people's quality of life. The registered provider's statement of purpose claimed they supported people access and provided annual holidays. We saw that apart from holidays organised for two people by relatives there were no other opportunities organised for people to access a holiday as claimed.

Where people had purchased their own furniture and electrical items, there were no systems in place to maintain personal inventories to differentiate people's personal belongings apart from those which belonged to the registered provider.

Plans in place for managing people's money, including the purchasing and consuming of alcohol and cigarettes were punitive, intended as punishment. For example, one care record stated, 'alcohol is removed if brought into the home, as there is a zero tolerance'. However, we noted there were no support plans in place to guide staff where we identified people, were assessed as vulnerable leaving the service to purchase alcohol, and drinking this in public places. The lack of support to manage substance misuse in the community is placing people who use the service and others including children in the community at risk of harm. There were no cessation or rehabilitation programmes in place with plans to rehabilitate, protect people and minimise restrictions on their freedom.

Alcohol and drug misuse is common among people with mental health problems and there is a complex relationship between them. Although issues and risks had been identified in people's care records, there was no treatment or recovery plans in place. This does not adequately support the risks associated with

these needs and ensuring people and others are protected from the risk of harm.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care

We asked to review the registered provider's process for responding to complaints. They told us they had not received any complaints. There was information displayed which guided people in steps they could take to make a formal complaint. The deputy manager told us they had a system to review on a six monthly basis the views of people who used the service, their relatives and staff. No responses had been received from people's relatives. Quality assurance questionnaires were completed for people who used the service alongside staff.

A review of staff survey responses included comments in response to their views on the 'standard of facilities'. One member of staff wrote, 'They could be improved but clients are quite clumsy'. When asked about the standard of cleanliness in the service, they wrote, 'It could be a lot better'. However, there was no analysis of responses received or actions planned in response to these comments.

The service was not currently supporting anyone who was believed to be at the end of their life. Care plans were not in place to evidence that people had been consulted regarding their wishes and any preferences they may have in relation to planning end of life care.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we rated this domain, Requires Improvement due to a lack of effective processes to assess, monitor and improve the quality and safety of the care that people received.

During this inspection we found that the provider had continued to fail to deploy a system of audits to sufficiently assess the cleanliness and suitability of the premises and environment. There was a lack of a clear vision and credible strategy to deliver high quality care and support, and promote a positive culture that is person centred, open, inclusive, empowering, which achieves good outcomes for people.

There continued to be a lack of systems in place to ensure effective oversight and governance of the service. The provider did not demonstrate they had systems in place to continuously learn from incidents, improve, innovate and ensure sustainability.

At this inspection we looked at how the registered provider's oversight and governance identified risks that may occur as part of the care and treatment they provided. We saw that risks in relation to the quality and safety of the service continued not to be consistently assessed or effectively managed. The provider continued not to have a system for auditing the quality and safety of the service. The deputy manager carried out some recorded audits but these had not identified the shortfalls we identified at this inspection.

Poor quality monitoring and governance systems had been identified as a concern at the inspection of the registered provider's other registered service. However, they had failed to react and take action to use the feedback provided to adapt governance systems to be more robust at Meadow View.

Records of audits showed these did not take place regularly. Audits in place and carried out by the deputy manager included; assessment of the general environment, staircase, lighting, medication storage, cleaning equipment storage, hot water and hot surfaces, pets, maintenance, waste, outside, and occupational health. They did not identify the issues we found at this inspection. The last record recorded as a 'general inspection' was carried out in July 2017. This stated 'carpet is in good repair, very dirty and significant wear and tear'.

We found incident and accidents had not been logged, investigated and actions taken in response to mitigate the risk of further harm to people. For example, where staff had made medicines administration errors. The provider did not have a continuous improvement plan to keep track of progress and ensure accidents and incidents of distressed behaviour with behaviour that may pose a risk to others did not reoccur. We discussed this with the registered manager who on day two of our inspection showed us an incident monitoring form they told us they had instructed staff to implement.

The service was not operating in line with its statement of purpose and information they provided on a public website. Staff did not understand or know what the vision and values were of the provider in line with their statement of purpose. Staff were confused as to what the aims of the service were. Staff told us they were employed to provide support but not personal care as per the provider's regulated activity. There was

no clear improvement plan, which involved and engaged staff or others in developing the service and the quality of care people received.

The staff supervision process was not fully embedded to ensure all staff received regular, planned and structured supervision to discuss and plan their training needs, review their performance and professional development. Systems were not in place to check the learning staff had undertaken was in line with the provider's statement of purpose, effective and to ensure their competency. For example, in the management of people's medicines and mitigating the risks to people with un-restricted windows, the risk of scalds from un-covered radiators and exposed water pipes or to take action where shortfalls had been identified in meeting the needs of people's health and welfare.

Cleaning schedules were not robust and records of what tasks had been completed were unreliable as it was clear many of these had not been carried out as stated due to the poor hygiene standards found on the first day of our inspection.

The poor oversight and lack of leadership had resulted in a lack of structure and direction for the staff team. Staff were unclear as to their roles and responsibilities and had not been provided with appropriate training or guidance to enable them to effectively carry out their role and meet people's needs. Staff were not recognising or managing risks accordingly. Staff did not have access to up to date and relevant risk assessments and care plans to allow them to provide safe and effective care.

The conduct and demeanour of the registered manager during our inspection did not evidence that they promoted a positive culture in the service. We observed they constantly used inappropriate language about and to staff. There was a lack of observed personal and professional boundaries when witnessing conversations between staff and the registered manager in the presence of people who used the service.

The lack of governance, oversight and knowledge of the needs of people who used the service in line with best practice and poor understanding of their responsibilities under the Health and Social care Act, 2008 meant the registered manager failed to demonstrate they had the knowledge and skills to safely provide a service to the people in their care. They had not researched best practice guidance in rehabilitation care for people with mental health conditions or consulted with external professionals as to the type of support they should be providing in planning people's care and support. They demonstrated a lack of knowledge in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which had led to restrictive practices being used within the service without appropriate assessment or consultation with people and others involved in their care.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance