Archangel Healthcare Ltd

Tendring Meadows

Inspection report

The Heath
Tendring
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Essex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Tendring Meadows is a residential care home providing personal care and accommodation for a maximum of 53 people. This includes support for older people who may be living with dementia or have physical disabilities. At the time of the inspection there were 29 people living at Tendring Meadows.

The accommodation at Tendring Meadows is situated across two floors, with four distinct units. During this inspection, one unit was being used for people who were isolating due to COVID-19.

People's experience of using this service and what we found
It was not demonstrated that sufficient staff were deployed to safely meet people's needs at night. Care plans and risk assessments had been completed but did not always contain sufficiently detailed information. Staff received training and competency assessments on medication, but medication audits were not consistently completed to identify any errors or poor practice. Whilst personal protective equipment (PPE) was being worn by staff and the service was clean and hygienic, some other areas of infection prevention and control (IPC) required improvement.

Whilst staff were seen to treat people kindly during the inspection site visit, feedback received from people's relatives did not describe a caring service. Relatives told us they felt excluded and unable to support people to be involved in planning their own care. Concerns were also raised about people being treated with dignity and respect, including a lack of access to their own clothing and glasses. People were not always supported to be independent with effective rehabilitation when discharged into the service from hospital.

Systems and processes for quality assurance, oversight and risk management were ineffective. The service had not demonstrated learning or made sufficient progress in this area, despite it forming part of the service's action plan following the last inspection. Some policies and procedures, including for the management of infection control and COVID-19, were out-of-date or not tailored to the service.

Opportunities to improve in other areas had not been actioned since the last inspection. For example, recommendations made for improving personal emergency evacuation plans, a maintenance plan for improving the environment and increased awareness of the Accessible Information Standard had not been developed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 26 April 2019) and there were multiple breaches of regulation. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. The provider completed an action plan after the last inspection to show what they would do any by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

We identified serious concerns about COVID-19 policies and procedures at the service. We wrote to the provider to set out these concerns before the end of the inspection. The provider's representative told us an action plan would be put in place to address our concerns about policies and procedures relating to COVID-19, including additional support for the registered manager.

Why we inspected
This inspection was prompted by a recent outbreak of COVID-19 at the service. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We carried out an unannounced comprehensive inspection of this service on 18 March 2019 and 22 March 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve notifications of incidents, safe care and treatment and good governance. This inspection was also prompted by our decision to check whether the provider had followed their action plan and to confirm they now met legal requirements.

We inspected and found there was a concern with safe care and treatment, treating people with dignity and respect, staffing numbers and governance and oversight, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe, Caring and Well-led.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tendring Meadows on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, dignity and respect, staffing and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We have raised our concerns with the local authority safeguarding team for investigation. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Tendring Meadows

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention (IPC) measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Tendring Meadows is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report. We used all of this information to plan our inspection.

During the inspection
We spoke with five relatives about their experience of the care provided for people. We spoke with nine members of staff including care workers, senior care workers, the chef, the deputy manager, the registered manager, the company director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed people's care and support in communal areas of the service.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
After the inspection site visit, we continued to seek clarification from the registered manager to validate evidence found. We raised concerns with the local authority safeguarding team for investigation.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to ensure medicines were safely managed at the service. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection, as the systems put in place to remedy our concerns were not effective or sustained, and the provider was still in breach of Regulation 12.

Using medicines safely; Assessing risk, safety monitoring and management; Preventing and controlling infection

- Following concerns at the last inspection, an action plan had been put in place by the service to formally audit medicine practices every month. At this inspection, the registered manager was unable to demonstrate any audits taking place between December 2020 and March 2021. This placed people at risk of harm as errors and omissions could be missed because they are not identified and corrected as soon as possible.
- When issues had been identified, they were not always followed up effectively. In November 2020 a medicine audit found where people had refused their prescribed medication, the reason was not always recorded on their medication administration record (MAR). Improvements in this area had not been made and this concern continued to be identified both in December 2020 and when auditing re-commenced in March 2021.
- The service action plan stated red tabards were "always worn" to ensure staff supporting with medicines were not disturbed. Although staff told us tabards were sometimes used, we did not observe any member of staff wearing a red tabard when administering medicines. This meant staff continued to be at risk of interruption.
- At the previous inspection people's transdermal patches had not always been given as prescribed. A transdermal patch is a medicated adhesive patch which is placed on the skin to deliver a specific dose of medication through the skin. At this inspection, MARs and body charts were being completed to show when and where patches had been placed. However, when a patch was recorded as not being in place on the day it was due to be removed, there was no further information on any impact this had on the person's pain level or confirmation of safe disposal.
- Care plans and risk assessments did not always contain sufficiently clear or detailed information. For example, one person's risk assessment said they required a soft diet to help them "swallow and digest food", but their care plan stated they had no swallowing difficulties.
- People were not always being supported to become independent following 'step down' hospital discharge into the service, with the aim to return home. One relative told us, "I think the staff at the home are

being too nice and doing everything for [person], instead of supporting them to be independent to enable them to go home." One relative shared how this had led to a decline in the person's mobility.
● When people were discharged from hospital, there was not always comprehensive information on how to support them available in their care records. One person's care plan showed they were at Tendring Meadow for rehabilitation following a fall, but there was no detailed information in their care records as to their aims and goals for achieving independence, or any timescales or metrics for success.
● At the previous inspection we recommended the service ensured people had appropriate personal emergency evacuation plans (PEEPs) in case of events such as a fire. Whilst PEEPs were in place for people, there was not always enough information included on potential risks.
● One person chose to have a stairgate over their door. However, there was no mention of this potential obstacle in their personal evacuation plan, which could be obscured by smoke in the event of a fire. It also did not confirm the reduced width of the door had been checked to see if the person could still be safely evacuated with the support of two staff.
● Another person spoke more than one language, but this was not recorded in their personal emergency evacuation plan to reduce barriers in communication during an evacuation.
● The registered manager told us all visitors would be screened for symptoms of COVID-19 and have their temperature checked prior to entry. However, the inspector was not screened at the entrance to the service. We asked the registered manager to complete these checks and to ensure all staff were aware of the process.
● People were being tested for COVID-19 prior to admission to the service, and self-isolating for 14 days. Whilst people were supported to self-isolate in one unit, their bedroom doors were not always shut in line with government guidance and no risk assessment was in place regarding this practice.
● The registered manager told us people were no longer being supported to socially distance in communal areas following a recent outbreak of COVID-19. We asked the registered manager to reinstate this safety measure, as no risk assessment was in place explaining any reason behind this decision.
● The premises were clean and hygienic, and cleaning schedules were in place. Some areas required remedial works to ensure thorough cleaning could be carried out. We raised this with the registered manager who told us this maintenance work would be promptly arranged.
● We observed staff using PPE effectively and safely. The registered manager told us staff had training and competency assessments on PPE 'donning and doffing'. We made some recommendations to improve donning and doffing areas and PPE storage. The registered manager told us this would be completed straight away.
● The provider's infection prevention and control policy was not up to date or tailored to the service, despite the COVID-19 pandemic having been ongoing for the past year. We have also signposted the provider to resources to develop their approach.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There was no robust system for checking there were sufficient staff deployed at night to meet people's needs.
● The local authority safeguarding team had recommended the provider review how it calculates staffing numbers: considering people's needs at night-time, the layout of the building and providing a clear rationale for how this was decided.
● At the time of inspection, three members of staff were deployed to support people at night, across four

separate units on two floors, as well as completing cleaning tasks.
● The tool used for calculating staffing numbers at night had failed to recognise the need to cohort staff to the COVID-19 isolation unit in line with best practice government guidance, and instead relied on a 'floating' member of staff to move between units and support with the care where two members of staff were required. The risk of cross-infection created by this practice had not been identified or assessed, and no amendment to staffing numbers made accordingly.
● No evidence of audits on turning and repositioning records or times taken to respond to nurse call bells were supplied upon request, although the registered manager told us these areas were reviewed if concerns were raised. This meant that effective systems were not in place to check whether staffing numbers were sufficient to meet people's assessed care needs and keep them safe from the risk of harm or poor quality care.
● Staff received training in a number of areas such as safeguarding, infection control and moving and handling. However, some people living at Tendring Meadows had a catheter in place. The registered manager told us staff had not received any formal training in catheter care. This meant they might not be able to identify early signs of complications such as blockages or infections.

Sufficient numbers of suitably qualified, competent and skilled staff were not deployed to ensure safe, good quality care. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment checks were completed including referencing and disclosure and barring service (DBS) checks, although one staff file had a discrepancy in their employment history which had not been explored.
● Records showed staff received supervisions and spot checks in areas such as PPE use and handwashing, and this was confirmed by the staff we spoke with. One staff member told us, "I recently had a supervision session on infection control and was taken to the PPE station to show [senior staff member] how I use PPE."

Systems and processes to safeguard people from the risk of abuse
● A safeguarding policy was in place at the service, and staff had received training in identifying and acting upon safeguarding concerns.
● Staff told us they would feel comfortable raising concerns with the registered manager and could explain how they would escalate to outside organisations such as the local authority, the Care Quality Commission or the police.
● The registered manager could not demonstrate how they effectively reviewed safeguarding concerns about people using the service for themes and trends to reduce the risk of re-occurrence.

Learning lessons when things go wrong
● Analysis of incidents and accidents at the service was not robust. The opportunity for learning, improving and mitigating future risk by considering what could have been done differently and sharing this with staff was not taken.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- Relatives told us they had difficulty contacting people living at Tendring Meadows. One relative told us, "I haven't spoken to or seen [person] since Christmas day." Another relative told us, "[Tendring Meadows] only has one phone, and this is for the office. We cannot get in touch and reassure [person]."
- Whilst staff were seen to treat people kindly during the inspection site visit, feedback did not demonstrate a consistently caring service. Systems were not developed to support people to manage contact with relatives and loved ones during the COVID-19 pandemic. Feedback included staff were unable to support people to engage with friends and family for advocacy and for their emotional wellbeing, as facilities were not in place.
- Whilst visiting had been paused due to an outbreak of COVID-19, alternative means of reliable communication had not been put in place. We were told by people's relatives there was often no mobile signal or internet connection, staff did not always know how to use video call technology and people's mobile phone batteries were not always charged. This included times people might need additional emotional support. One relative said, "When [person] was in the isolation unit there was no reception on their phone."
- Whilst some relatives told us they had received updates from the service, this was not always carried out in a caring and respectful way. One relative told us a member of staff had been "rude" and "aggressive" over the telephone and, "It is very upsetting not being able to contact [person] and worrying about contacting staff due to the attitude we have experienced." Another relative told us it, "Feels like an irritation [to staff] when we ring" and did not feel comfortable calling as often as they would like.
- People did not always have their privacy respected when communicating with their relatives. One relative told us there is, "No privacy on the [video] calls, which are in a little office, staff kept coming into the office during the call." This was contrary to the provider's statement of purpose, which says people, "May use a telephone in private whenever they wish to do so" and, "Staff will never enter a room without knocking first."
- Relatives raised concerns people did not have access to their own clothing. One relative told us a person was not wearing their own clothes and, "Staff have lost [person's] slippers and they wanted to wear their shoes, but staff did not give them time to put them on to go to the lounge". Another relative told us, "[Person] is wearing strangers' clothes. We bought all new clothes however were not told to label them. All nighties, underwear and clothes have disappeared." This did not respect people's dignity or treat them as individuals.
- Whilst staff were observed to speak with people in a reassuring and caring way, they did not have access

to information on how to communicate with people effectively. One person spoke a language other than English when distressed but the language was not recorded in their care plan. The registered manager could not tell us this information when asked. Steps had not been taken to find out the language spoken or determine whether a translator was required to support the person to express their needs.

● People did not have access to the aids required for them to communicate effectively. One person's relative told us, "[Person] wasn't wearing their glasses on the [video] call and is visually impaired." The impact on the person's ability to engage and communicate fully with their family had not been recognised.

People were not supported in a way that ensured their privacy, dignity, autonomy and independence. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst there was no evidence to suggest people had been harmed, not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
- Records provided relating to quality assurance audits and checks failed to demonstrate the quality and safety of care provided was being effectively monitored in all areas of the service. These shortfalls had not been identified by the provider's systems.
- Whilst the registered manager had knowledge of the service on a day to day basis, there were no systems in place for long term oversight of areas such as accidents and incidents or safeguarding to mitigate risk and drive improvement.
- Policies, procedures and risk assessments for infection prevention and control, including the management of COVID-19, were not always complete, in line with up-to-date government guidance or tailored to the service. For example, there was no evidence the provider's infection control policy dated March 2016 had been reviewed to include the management of COVID-19.
- The business continuity plan supplied by the registered manager was in the name of another care home and contained out of date information. This did not demonstrate plans were in place in case of emergencies, such as extreme staff shortages during the COVID-19 pandemic.
- We wrote to the provider's representative expressing serious concerns at the failure to adequately assess the risk of and consider ways to prevent and control the spread of infections, including COVID-19. The nominated individual acknowledged our concerns and told us that steps would be taken to resolve this, including additional management support.
- The service was not consistently well managed, and we found continued breaches of regulations. Effective measures had not been put in place by the provider to resolve previous concerns and demonstrate learning.

● The provider had failed to meet many of its action plan objectives from the last inspection, and any quality improvement made was not always sustained.
● Recommendations made at the previous inspection to improve the quality and safety of care had not been carried out.
● Understanding of the importance of equality, diversity and a person-centred approach was not evident at management level. Feedback received from people's relatives did not suggest a culture where people were supported in a positive, inclusive and empowering way.
● Staff were observed to be caring and kind but did not have enough information available to support people to regain their independence. This could impact on people's long-term goals.
● Whilst some relatives told us they were contacted about changes to people's health, we also received feedback that relatives felt excluded and were not involved in their loved one's care. For example, one relative told us they did not know whether a 'do not resuscitate' order (DNACPR) was still in place for a person.
● The provider could not demonstrate they sought the views of people, professionals and relatives as no formal quality survey had been completed since 2019. The registered manager told us after the inspection they had begun regularly asking people if they were happy with the quality of their care.

The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to notify the Care Quality Commission of all incidents that affect the health, safety and welfare of people who use services. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18 (Registration).

● The registered manager had informed the Care Quality Commission of events that occurred, such as safeguarding concerns. Notifications are required by law to ensure the CQC can monitor the service and ensure people are receiving safe care.

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● When the service experienced problems or challenges with information provided about people during hospital discharge, it was not demonstrated they had raised concerns about this process to other organisations to reduce the risk of reoccurrence.
● The registered manager had worked with professionals such as the Clinical Commissioning Group (CCG), quality improvement team 'PROSPER' ('Promoting Safer Provision of care for Elderly Residents') and the local authority safeguarding team, although suggestions made were not always effectively implemented.
● We signposted the provider to further resources and organisations that could provide support, advice and guidance on how to improve the service.
● A duty of candour policy was in place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not supported in a way that ensured their privacy, dignity, autonomy and independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent and skilled staff were not deployed to ensure safe, good quality care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Warning notice