Bupa Care Homes (ANS) Limited

Meadbank Care Home

Inspection report

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17 January 2018
22 January 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Meadbank Care Home on 16, 17 and 22 January 2018. At our previous inspection in July 2017 the home was rated as Requires Improvement with three breaches of regulations relating to assessing the risks to the health and safety of people and not doing all that was reasonably practicable to mitigate any such risks. We found further that the provider did not always ensure the proper and safe management of medicines and did not always provide care in accordance with the Mental Capacity Act 2005 (MCA) and did not always ensure the nutritional needs of people were met.

As part of this inspection we were responding to the high volume of safeguarding concerns the CQC had received from the London Borough of Wandsworth, Wandsworth Clinical Commissioning Group and the number of complaints we had received from relatives and friends of people who use the service.

Meadbank is a 'care home'. People in Meadbank receive accommodation, nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered for 176 people and 154 were receiving care on the days of the inspection. The home is based on four floors, each named after a different London bridge (Albert, Chelsea, Lambeth and Westminster). Each floor has a private wing and the private wing is collectively called "London Bridge". The number of people and staff on each floor varied in response to their needs. Two of the units specialise in providing care to people living with dementia.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Shortly after our inspection we received information that the registered manager was no longer working at Meadbank.

Following the previous inspection, we asked the provider to complete an action plan, with a timescale, to show what they would do to address the breaches of regulations we found, and improve the areas of Safe, Effective, Caring and Well Led to a standard that was at least "Good". At the previous inspection in July 2017 we did not look at the area of Responsive.

With regard to the breach of regulation in relation to safe care and treatment, we found that the provider had not followed their action plan to meet the legal requirements of this regulation. We found that the pre-admission assessments were insufficiently detailed to build a detailed care plan for a person and so to mitigate the risk to them of receiving inappropriate care. Where specific risks had been recorded we saw that there was insufficient detail to help mitigate against the risk occurring.

We found the provider had not followed their action plan to meet the legal requirements in regard to the correct management and administration of medicine. A type of needle being used did not protect staff

against the risk of an accident. The suction machine was not ready for use if a person was choking. Blister packs of medicine were not stored securely. The extended length of time taken to complete a medicine rounds meant that people may receive their medicine later than prescribed.

At this inspection we identified five fresh breaches of regulation in regard to Staff, Premises, Safe Care and Treatment and Good Governance.

With regard to Staff we found that there were insufficient staff on duty to meet the needs of people in a timely manner. Although we observed staff interacting with people in a kind and dignified matter, staff were rushed at times and there were periods when staff were not visibly present on the units and not available should a person require assistance.

We found further that the provider did not provide staff with appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to do. The provider acknowledged there were gaps in staff training and staff support.

With regard to Premises we found that people were not protected against the risk associated with the cleanliness of the building as the systems and processes in place to minimise those risks were not effective. The provider had not taken all possible action to prevent the control the spread of infections. We also found the premises were not maintained sufficiently to ensure people were living in a safe environment.

With regard to Safe Care and Treatment we found that staff did not always support people in a way that met their health needs. Although some of the evidence we saw showed there was good multidisciplinary working with people being referred to appropriate specialists, this was not always the case as was evidenced in the number of serious safeguarding alerts that we had received where people's healthcare needs had not been met.

With regard to Good Governance we found that the provider did not have effective quality assurance and governance arrangements. The quality assurance systems the provider had established were not effectively operated as they had failed to pick up a number of issues we identified during our inspection. These included a high percentage of staff not having up to date training in some key aspects of their role, poor hygiene and maintenance throughout the home and gaps in their health and safety checks. There were also ineffective systems in place to gather the views of people, relatives, staff and healthcare professionals and act on their concerns, to improve the quality of care delivered at the home.

During our inspection we observed the majority of the environment had not been adjusted for the people who were living there, despite listing Alzheimer Disease as one of its specialist care categories on the home's website. We felt that better signage, decoration and adaptations to the premises would help to promote people's independence. For those people who required staff support better signage would be beneficial in avoiding potential distress to people who became disoriented. We recommend that the service seek relevant guidance and research on the design of the environment for people living with dementia.

The home had three activities co-ordinators who were responsible for planning and implementing activities that people wanted or would perhaps like to try. The type and level of activities on each unit varied. There was no external or internal support or training for the activities coordinators. We recommend that training and access to other, external, examples of how activities in care homes work well would help professionalise the practice of activities coordinators as well as supporting their existing commitment and work.

BUPA had introduced a new system for recording incidents and accidents in October 2017. This system was

not yet fully operational at Meadbank.
Staff were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence.

The service had carried out proper recruitment processes and checks with staff. These checks helped to ensure that people were cared for by staff suitable for the role.

People's nutritional needs were being better met during this inspection than previously but there were still areas that needed to be improved. For example, drinks were not always available to people when they were in their bedrooms.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People's consent to receive care in accordance with the MCA had improved since the last inspection.

People were supported to eat and drink sufficient amounts to meet their needs and their dietary requirements were detailed in their care plans. Staff were aware of the different diets that people needed and were able to tell us about people that may need different food due to religious beliefs or personal preference.

Before the inspection we had received numerous complaints from visitors and relatives about poor staff care and interactions with their relative. We used this information to observe how people were cared for and to ask people and relatives what they thought of the staff at Meadbank and how they were treated. Our own observations were that most but not all staff greeted people warmly and by their preferred name. In the communal lounges, most but not all staff were friendly and encouraged people to join in conversations and with any group activities that were taking place.

People and relatives said they had some involvement in the development of their care plans but were unsure when or how often it was updated. Care plans were written in a person centred way and focussed on the person's care needs, abilities and choices.

Meadbank was responsive to meeting the cultural needs of people from different backgrounds. We saw there was information about local advocacy services available, detailing which languages the service spoke and could assist with. Leaders from different religious orders visited the home either weekly or fortnightly and anyone was welcome to attend the services they conducted.

The service had arrangements in place to respond to people's concerns and complaints. People and their relatives told us they knew how to make a complaint if they were not happy with the service provided at the home.

CQC had also received a large number of complaints about the service from friends and relatives and although we do not investigate individual complaints we did look at the themes of the complaints at this inspection. The records we looked at did not clearly detail how complaints had been responded to, if in fact they had been responded to.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider did not have effective systems to assess, review and manage risks to ensure people's safety.

People's risk assessments were insufficient to meet people's needs.

The provider did not have suitable arrangements to protect people against the risks from the unsafe management of medicines.

At the time of the inspection there were not enough staff to meet people's needs.

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

Is the service effective?

Requires Improvement

The home was not always effective.

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

Effective arrangements to support people with their healthcare needs were not always in place.

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

Is the service caring?

Requires Improvement

The home was not always caring.

People's privacy and dignity were not always respected.

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

Many but not all the staff were caring towards people.

Is the service responsive?

Requires Improvement

The home was not always responsive.

Care plans had not been updated to take into account people's changing needs. There was no proper care planning around pain management.

The provider had a programme of activities; however there was an insufficient variety and access to activities for all the people at Meadbank.

The provider had a complaints policy and a procedure to respond to people's concerns and complaints. However complaints were not always responded to in a timely manner or to the satisfaction of the complainant.

Is the service well-led?

Inadequate

The home was not well led.

The provider did not have adequate quality assurance systems.

People and relatives were not always asked for their feedback on the care they received in a meaningful way that could produce change.

Meadbank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection was carried out in response to a high volume of safeguarding concerns about the quality of the service provided to people that the CQC had received from Meadbank (in accordance with their regulatory responsibility to inform us), the London Borough of Wandsworth and Wandsworth Clinical Commissioning Group. Several of these safeguarding concerns are subject to a criminal investigation and as a result this inspection did not examine the circumstances of these incidents. CQC also received a number of complaints from relatives of people who use the service. Meadbank was also subject of an 'all home' safeguarding concern where the local authority had placed an embargo on any new admissions to the home from 19 December 2017.

CQC was aware of injuries sustained at Meadbank which is why we explored particular aspects of current care and treatment during the inspection. The overall concerns from the safeguarding alerts and the complaints we received were around falls, hydration, nursing practice, infection control and neglect. This inspection examined those risks.

This inspection took place on 16, 17 and 22 January 2018 and was unannounced on the first day and first evening. We told the provider we would be returning on the second and third day.

The inspection was carried out by four CQC inspectors, five experts by experience and two specialist advisors who were both senior registered nurses. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service for example elderly, dementia and palliative care.

We reviewed the information we had about the service prior to our visit and we looked at notifications that the provider is legally required to send us about certain events such as serious injuries and deaths.

During the inspection we gathered information by speaking with 60 people living at Meadbank and 17 relatives and friends who were visiting the home. We spoke with the registered manager, the deputy manager and a total of 49 staff, including registered nursing staff, healthcare assistants, domestic and maintenance staff and the activity co-ordinators. We spoke with three people from the registered provider company BUPA; these were the managing director for BUPA, the regional clinical lead support and a regional director. We also spoke with a visiting GP, the community dietitian, a visiting Best Interests Assessor and the physiotherapist.

We observed care and support in communal areas in an informal manner. We looked at 31 care records and seven staff records and reviewed records related to the management of the service.

Inadequate

Is the service safe?

Our findings

On 10 July 2017 we inspected the service and identified a breach of the regulation in relation to safe care and treatment. We found that the provider had not carried out appropriate risk assessments and had not ensured risks had been identified and mitigated. This information would be used to prepare care plans and risk assessments in specific areas of a person's care including moving and handling, nutrition, hydration and wound care.

Following the inspection the provider wrote to us and told us they would make the necessary improvements and address all the above concerns by 31 October 2017, by ensuring any risks identified were managed appropriately and identified within each person's individual care plan documentation.

At this inspection, we found the provider had not followed their action plan to meet the legal requirements of this regulation. We could see in the care plans we looked at that pre-admission assessments had been completed. However we found that some of the pre-admission assessments were insufficiently detailed to help build a comprehensive risk assessment for a person. Each care plan we looked at had a variety of risk assessments with information taken from the pre-admission assessment. For example one care plan showed a person was at risk of pressure ulcers, had lost significant weight and was immobile when in bed. The loss of weight and the ability to change position were important factors in helping to ensure good skin integrity.

We also tracked the care of a person who had been assessed by the on-site physiotherapist as requiring specific help to mobilise. However these recommendations were not readily available in the person's care plan. We saw care plans clearly identified people's behaviours that might be perceived as challenging. However, the risk management plans that were in place to help staff prevent or de-escalate such incidents were not sufficiently detailed. In addition, it was not clear if any input had been obtained from external professionals, such as the challenging behaviour team, in order to help staff develop appropriate challenging behaviour risk management plans. The lack of details we found and the actions staff should take to keep people safe may mean that people were still at risk.

People were not protected against the risks associated with the prevention and control of infections because the building was not clean. We saw and staff demonstrated that only one type of liquid cleaner was used for all the different surfaces and areas of the home and that changeable mop heads were used in the different areas. Although on speaking to staff it wasn't clear if they actually changed the mop heads between different areas of a person's room, for example the bedroom and bathroom areas. In several areas of the home there were strong malodorous smells, including in people's bedrooms, carpets, in the corridors and in the stairwell areas. We saw numerous examples of unclean areas of the home, buttons on call bells which had not been properly cleaned, dirty sinks and toilets, dirty chairs in communal areas and dirty windows. Staff were observed to be wearing apron and gloves when supporting people with personal care, however these were not available in people's rooms, which may help against the spread of infections and germs. There were insufficient hand sanitiser dispensers in the corridors to help prevent infection when staff were going into bedrooms. We noted that waste bins did not identify which bins were for clinical waste and which

were for domestic waste. The concerns identified in the above paragraphs continue to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The discrepancies above were not found on all the units, on one of the units pre admission assessments were completed well and people's condition or circumstances detailed in their care plan. We found staff on some units were knowledgeable about the individual risks posed to people and were able to explain clearly how these should be minimised to protect them. There were clear signs on bedroom doors where oxygen was in use and in rooms where oxygen was stored. We also noted that on each hoist there was clearly displayed a card detailing good moving and handling procedures with pictures.

During the previous inspection of 10 July 2017 we identified a second breach of the regulation under safe care and treatment. We identified concerns in relation to administering and storage of medicines. Following the inspection the provider wrote to us and told us they would make the necessary improvements and address all the above concerns by 31 October 2017.

At this inspection, we found the provider had not followed their action plan to meet the legal requirements of this regulation. We saw that the type of needles being used to administer insulin were a non-re-sheath style which left staff at risk of being scratched or pierced with this type of needle. The suction machine to be used if a person was choking was not charged and therefore not ready for immediate use. On one unit the blister packs of medicine, together with some other medicines were not stored securely. The length of time taken to complete a medicine rounds could be between an hour and an hour and a half this may mean that people received their medicine later than prescribed. The concerns identified in the above paragraphs continue to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see that clinical rooms were locked and the key held securely by the RN. The medicine fridges and room temperatures were measured daily. Controlled medicines, the corresponding record book and the controlled medicines disposal kit were all stored correctly. PRN medicines were stored and recorded correctly. We observed that nurses in charge of administering medicines wore a 'do not disturb' red tabard, which staff respected. Staff we spoke with about medicines and administration of medicines were able to answer our questions and were knowledgeable about the use of different medicines. We checked a sample of all medicines within all of the cupboards and found them to be in the correct boxes and within their expiry date.

We received mixed comments from people living in the home and visiting relatives about staffing levels. One person said, "The staff are certainly committed, but I think it's hard for them when they're always short staffed", while a relative told us, "My [family member's] keyworker is fantastic, but there's not always enough staff on shift which makes their job impossible." We received similar comments from staff, one member of staff told us, "I think we do have a problem with staff ringing in sick at the last minute which is impossible to cover", while another said, "I think we need more staff on the unit. We need to use the mobile hoist to help so many people to get up or transfer to the dining room, which means two staff are always needed to support one person."

Although we mainly observed staff interacting with people in a kind and dignified matter, we did see staff were rushed at times. For example, on the first day of our inspection we saw people sitting at the dining room tables had to wait 15 to 20 minutes for their meal to be served. There were times when staff were not visibly present in the communal lounges where people were sitting. Call bells were not always available in the communal spaces which meant people might not be able to alert staff whenever they needed them.

We looked at the staff rotas for three of the units for the month of December 2017 and January 2018, plus the support team rota (managers, domestic staff and activities). Staffing ratios varied between units but the number assigned did not appear to be based on people's needs. For example, on one unit with a total of 43 people resident, over a two day period in January the number of staff on duty varied between seven and 12 healthcare assistants (HCA's) during the day. Over a two day period in December 2017 the number of staff varied between three nurses and 14 HCAs to two nurses and seven HCA's. Night staffing was also a concern. Over four days in December there were only three staff working (one nurse, two HCAs) on a unit with 43 people with advanced dementia. Staff who supported people on a one-to-one basis were included in the rota of total staff even though they only worked with one person. We saw that in the afternoons on two of the inspection days that due to staff training there were limited numbers of staff to care for people. The concerns identified in the above paragraphs were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a long standing issue with vermin, mainly mice getting into the home, including in communal areas, kitchens and bedrooms. We saw mouse traps on all the floors in various places, we also noted two of the traps had mice in them and were waiting for the contracted company to call and remove the mice; they did this on the second day of our inspection. The provider had undertaken some work to eliminate the problem, the kitchen and laundry room had sealed up any holes where mice might get in and both rooms were being kept clean and food and waste stored securely. However, appropriate action had not been taken on the units. We saw food waste in unsealed containers in the unit kitchens, open food packets left on shelves and opened bottles of squash stored on the floor, with one bottle stored beside an occupied mouse trap. The unit kitchens and dining areas we looked at were not clean with food spills running down the walls, dirty food trolleys, work tops, sinks and floor surfaces. Holes around toilet outlets, baths and sinks, gaps around radiator pipes had not been sealed to prevent mice getting in.

The overall décor of the home was poor with chipped paint on doors and broken tiling in bathrooms. We found several mattresses where the outer waterproof covers had been ripped and were severely stained and malodorous. We saw sluice rooms and bathrooms being used for the storage of equipment, hoists, wheelchairs and cleaning trolleys, and a hoist and wheelchair being stored in a unit kitchen. Making these rooms difficult to use for the purpose they were intended.

Call bells were not always available to people when they were in communal areas or their bedrooms. We saw several call bells in bathrooms and toilets that were tied up and not available should a person fall.

Recorded evidence to show Portable Appliance Tests (PAT) had been carried out annually was inconsistent. Although we saw PAT labels on appliances which indicated they had been tested, the dates they were checked was missing from these labels. When this was pointed out to management the labels with dates were replaced.

The temperature on a hot food trolley on one unit was too low to help control the multiplication of bacteria in hot food. The displayed insurance policy was out of date by two months; this was changed when we pointed it out. The Legionella report we were shown had found positive readings in September 2017 and we were unable to find evidence during the inspection that the recommended actions had been taken. We were later sent documents that indicated action had been taken. We found actions identified in the Fire Risk assessment had not been completed. The fire panel and escape routes that should be checked daily had not been checked on the 10 and 11 January 2018. A fire door was noted as not closing correctly in three consecutive months, up to December 2017. The concerns identified in the above paragraphs were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The concerns we found above were in marked contrast to the private units of the home which were clean, generously carpeted and fresh smelling.

BUPA had introduced a new system for recording incidents and accidents in October 2017. Management told us the system was "being used much more effectively in other BUPA homes" so they were seeing how that good practice could be replicated in Meadbank as it "was not really embedded here yet." Once this electronic system was fully used by staff the process will help to keep people safe and actions can be put in place to avoid a reoccurrence of the accident.

Despite the failings highlighted above, people and their relatives had positive comments and told us that they felt personally safe in the home. Comments we received included "I do feel safe here," "Nobody hurts me, no one troubles me, I'm okay," "Yes I know she's settled and comfortable now. She says she doesn't want to leave and is settled" and "Oh yes she's so well looked after night and day, the night nurse come in to her every hour to look after her and [named staff] is excellent as well as the nurses." These comments were supported by a visiting speech and language therapist (SALT) who told us, "I think people living here are safe."

The majority of staff were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence, however we also spoke with staff who needed a lot of prompting as to their understanding of safeguarding adults. Records showed over a quarter of the home's staff team had not refreshed their safeguarding training in the past year, and 150 staff had training that was overdue, contrary to the provider's safeguarding training policy.

The service had carried out proper recruitment processes and checks with staff. This included a completed application form and interview, criminal record checks, proof of eligibility to work in UK and two references. There was an induction and shadowing period before staff commenced work on their own. These checks helped to ensure that people were cared for by staff suitable for the role.

Requires Improvement

Is the service effective?

Our findings

On 10 July 2017 we inspected the service and identified a breach of the regulation in relation to meeting nutritional and hydration needs. This is because the provider did not keep accurate records of people's nutritional needs and fluid intake. People's care records did not always record accurately their Malnutrition Universal Screening Tool (MUST) which helped to identify whether a person was at risk of malnutrition or dehydration. The correct consistency of diet, pureed, soft, mashed was not always given to people.

Following the inspection the provider wrote to us and told us they would make the necessary improvements and address all the above concerns by 31 October 2017, by ensuring people's nutritional health was monitored and recorded correctly.

At this inspection, we found that whilst the provider had taken action to meet the legal requirements of this regulation, there were still areas that needed to be improved. People did not always have access to drinks outside of mealtimes and drinks in people's rooms were not always within reach, so they could help themselves to drinks at any time. One person commented, "I can't always reach my drink, so I call the staff. They come eventually. I could do with more drinks" and a relative told us, "[My relative] doesn't always have a drink in her room and she spends a lot of time in there. Also in the lounge they don't often have a drink." We were told each unit had a hydration care assistant who was responsible for ensuring people had drinks available to them, however we could not always identify who this person was. We did see good evidence of food and fluid balance charts being completed. Swallowing guidelines in people's daily records and the use of thickening agents for drinks protocols were also in place. All of the records that we reviewed had a MUST completed on admission and then updated monthly, this included people's weight.

Also at the 10 July 2017 inspection we identified a breach of the regulation in regard to the need for consent, because the provider did not always provide care in accordance with the Mental Capacity Act 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We found that capacity assessments were conducted inconsistently and where assessments were required these had not been completed.

Following the inspection the provider wrote to us and told us they would make the necessary improvements and address all the above concerns by 31 October 2017, by ensuring consent was discussed with people and staff received additional training on the Deprivation of Liberty Safeguards (DOLS) and on the mental capacity assessment process.

At this inspection, we found that whilst the provider had taken action to meet the legal requirements of this regulation, there were still areas that needed to be improved. 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. From the care plans we looked at we found capacity assessments were completed and kept in people's records and that specific best interests decision making records were also kept when this was required. However, some best interest decisions we saw were made by just one staff member and the forms did not record that anyone else was involved or consulted, such as the person's family or other professionals involved in their support.

The best interests' assessor we spoke with said that some staff did not fully understand the decision making process under MCA. They said "Capacity assessments have improved a lot over the last few months, Meadbank are doing their best but there is still some work to do." Some people's assessments recognised that people had varying capacity and so had guidelines for staff about how to approach passing on information for decisions, such as the best time of day when the person was more likely to be able to understand. We saw that people had signed their care plan to indicate they agreed to the support provided.

The provider did not provide staff with appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to do. However staff spoke positively about their role and their work at Meadbank. Comments from staff we received included "I love coming to work here and enjoy working with my team," "I enjoy the training I've received and I feel supported by the senior staff," "I think the training we have here is very good" and "We do get a lot of on-going training from BUPA."

Although staff told us that they felt supported, they were unsure about the frequency or purpose of professional supervision and could not tell us how regularly they received it. Staff records we sampled indicated that the practice of individual supervision had become very infrequent. For example, we found gaps of six to 10 month between supervision meetings. Staff appraisal, an annual performance monitoring process, had not been carried out for some staff, whilst for others the latest appraisals were for 2015 and 2013. Unit managers told us they should hold monthly meetings with staff, but this was not happening because of time restraints and pressure of work.
With regard to staff training, the service's internal audit had shown an overall 66% compliance rate for all staff on required training. This included training in safeguarding adults, nutrition and hydration, Mental Capacity Act awareness and DoLS, managing behaviours that challenged the service and caring for people with dementia. This would indicate that staff would be effective in supporting people.

However we found on further investigation of the training records that staff had completed much of this training prior to 2016 and some as far back as 2011 and 2014. We found training assigned to be completed in 2017 had not happened. Records showed only 60% of staff had received training in moving and handling but 47% of those had received the training prior to 2017. Less than half the staff who required medication management level two training had received it. However 12 staff had completed this training between 2010 and 2014 and records showed of the 10 staff assigned to complete this training in 2017 none had completed it. Only 86 out of the 196 staff had received training in the principles of the MCA since 2015 but only 15 staff had received updated training in 2017.

An overview of the training undertaken by the registered nurses, clinical managers and senior care assistants showed a high incidence of training which was either overdue or which had last been completed more than three years ago (2014 and older). Records showed that none of the home's staff had completed the fire awareness training in 2017, as recommended by the Fire Risk Assessment conducted in November 2017. The concerns identified in the above paragraphs are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and area training manager both acknowledged there were gaps in staff training and

the provider's quality monitoring systems would need to be improved to ensure all staff member's knowledge and skills were continually kept up to date.

With regard to access to other healthcare professionals people we spoke with commented "I tell them and they organise the GP to come. I have waited a few days at times and they tell me to rest in bed," and "They usually know if I'm ill because I will stay in bed which they have no problem with and they ask if I need pain killers. You can have them when you like. If you ask to see the doctor you wait until they come. I think I've waited a few days at the most."

However staff did not always support people in a way that met their health needs as was evidenced in the number of serious safeguarding alerts we had received where people's healthcare needs had not been met. Records showed that actions had not been taken to minimise the pain and discomfort to people by the prompt intervention of other healthcare professionals.

Through the local authority safeguarding process we had heard about pressure ulcers that had gone undetected and treatment had not been given. Also people who had falls not receiving prompt care because staff did not refer them to the GP service at weekends and the person was left for two or three days without medical help. In these case staff said they had taken observations of the person, such as blood pressure, pulse and temperature but these observations were not written down and could not be found when asked. The safeguarding process also found the correct procedures had not been taken when a person may have received a head injury when they fell.

When because of a person's deteriorating health an ambulance was called, the person on admission to hospital was found to be dehydrated and in some cases had broken limbs that had not been detected. In these cases the hospital had raised a safeguarding alert to protect the person. The registered manager told us about the homes policy in response to emergencies and the process taken. However, the information in people's care records and the information given at the safeguarding meetings demonstrated that this procedure was not always followed by staff.

The home had a contract with a GP surgery to visit the home daily and to be on call out of hours and at weekends. We spoke with one of the visiting GPs and they told us people or staff could request for a person to be seen during the GP's visit and all people were seen and their healthcare reviewed annually or more often if needed. The contract with the GP practice was due to end on the 31st January 2018 and no replacement GP practice had been found on the 30th January 2018. We have since heard that the current GP practice will continue on an interim basis until another GP practice is found to take over the service. The concerns identified in the above paragraphs continue to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did find evidence to show that in some cases there was good multidisciplinary working with people being referred to appropriate specialists, such as the community podiatrist for a person with diabetes, the speech and language therapist, and the dietitian service. We also saw several cases of pressure ulcers that had been appropriately assessed and good care given, with the result that these ulcers had healed.

During our inspection we observed the majority of the environment had not been adjusted for the people who were living there. Many of the people living in Meadbank had dementia with varying degrees of severity. Other people were physically frail, or had sensory disabilities such as communication or sight impairment. The home's website and other information described the home as being suited to care for people with Dementia, Mental Health Conditions, Old Age and Physical Disability. It also stated on the website that they provided "specialist" care to people diagnosed with Alzheimer's disease.

We saw some signage to help people orientate and to identify important rooms or areas such as their bedroom or the lounge, varied throughout the building. Bedroom doors and hallways had been painted identical neutral colours and this lack of colour contrast meant a lot of the communal areas, especially the corridors, looked identical. On the outside of a person's room was a name plate and a memory box, these were used as a visual reminder to people that this was their room. We found many of the boxes and name plates were empty. Bathrooms and toilets lacked a visual aid to identify the room. Visual aids might help people living with dementia orientate themselves and find their way around the home more easily.

We saw the communal lounge in one unit had clearly been used for staff training, which the unit manager confirmed. Consequently, this communal area was not an inviting place for people to come to together and socialise. This increased the risk of people becoming socially isolated in their bedrooms. The majority of the bedrooms were very small, with only enough room for a bed, a dresser and a wardrobe. People who received visitors to their rooms had nowhere for them to sit. This added to the fact there were no areas on the units where families could sit together in private. We also found a lot of the paintwork on bedroom doors and in communal areas, such as the lounge and dining areas, were badly scuffed and chipped. We also saw large numbers of wheelchairs and mobile hoists stored in communal areas such as the main lounge which made the space look rather cluttered and un-homely.

Most of the people we spoke with and observed required personal support from staff with moving about. However, we felt that better signage, decoration and adaptations to the premises would help to promote people's independence and be beneficial in avoiding potential distress to people who became disoriented.

We recommend that the service seek relevant guidance and research on the design of the environment for people living with dementia.

People were supported to eat and drink sufficient amounts to meet their needs and their dietary requirements were detailed in their care plans. People when asked about the food commented "It's okay. You get a choice or two. I eat in the dining room. They help if you ask but they are very busy," "I eat my meals in my room and they bring me everything I need, it's not too bad and I get a couple of choices and a pudding and fruit if I want it," "They help me to cut things if I need it. I like the dining room because you can have a chat and listen to a bit of music" and "The food isn't bad and the dining room is livelier than the lounge or my room. It is a bit messy at times and they don't always clean the cloths on the table." Relatives commented "Food looks okay and there are choices. The dining room is a bit busier and more going on and my relative treats it like a day trip. She enjoys the whole dining experience here" and "[My relative] has meals in his room, his choice and they do help him or offer him help and he gets everything he needs and snacks."

We could see there were different menus displayed each day; however we found the picture on the menu was generic and did not correspond to the food being served. This may cause confusion to some people. The chef told us they spoke to people and their families on admission regarding people's likes, dislikes and food preferences and the home was able to cater for people's different nutritional and religious needs.

We observed lunch on the separate units and staff who supported people on a one to one basis used appropriate techniques (sitting down with the person, asking them what they wanted). Meals appeared appetising and portion sizes looked good. People who did not want the food offered were offered alternatives, and staff were very encouraging of people to try to get them to eat. Drinks were offered with the meal including tea, coffee, water, milk and juice.

Requires Improvement

Is the service caring?

Our findings

Through the safeguarding investigation meetings by the local authority, which the CQC attended, we had heard about poor staff care of people. Before the inspection we had also received numerous complaints from visitors and relatives about poor staff care and interactions with their relative. We had heard of staff shouting at people, speaking unkindly and being unhelpful to people and their relatives.

We used this information to ask people and relatives what they thought of the staff at Meadbank and how they were treated. We received mixed feedback from people and their relatives although most people typically described the staff as "kind". Comments included, "I would have expected better care from a well-known company like BUPA, but to be fair my [family member's] keyworker is amazing", "I think the staff do a marvellous job in difficult circumstances. I just don't think the place is particularly well managed" and "I like living here. I'm very well cared for by the staff. They're a lovely bunch." "They give me the care I need and no more but I am quite happy with that. Sometimes they have time for chats," "[Staff] are caring and kind and will help as much as they can" and "Yes they are [kind] and [named care staff] is special, they have a special quality and warmth about them with the residents".

We also received the following comments about staff, "Some staff are ok, some have a terrible attitude, they have a very arrogant way about them and shout at my relative even when I'm there." We heard from relatives that any issues they had with staff rudeness was reported to a senior member of staff and dealt with by them. One person commented "Some staff take a long time to get friendly with you, some do it a lot better than others. It's because they don't have anything to talk to you about and their English is not always great but once they start its ok."

Staff expressed a positive attitude to working at Meadbank. Many staff had been there for a number of years and told us they wished to continue working there. Staff commented to us, "I had [my relative] living here. I think that says it all about how caring I feel the home is," "Residents are like members of our family" and "It's like looking after my own family."

We saw staff greeted people warmly and by their preferred name. In the communal lounges, staff were friendly and encouraged people to join in conversations and with any group activities that were taking place. Staff also responded positively to people's questions and requests for assistance. For example, we observed a member of staff get a blanket to cover someone after this person had said they felt cold. We observed some lovely interactions between staff and people, including one care worker stroking a lady's hand and speaking in a soothing voice which the lady found very calming. People behaved and responded comfortably and at ease with care staff.

People and relatives we spoke with told us they felt that the care staff treated them with kindness, respect and dignity. One person told us, "They're [staff] lovely people. I am very happy here." A relative told us, "It might not be the fanciest home, or the prettiest. However, [my relative] is well cared for and I go home confident that staff are kind and that they understand [my relative's] needs." Personal care was attended to in the privacy of people's bedrooms, bathrooms or toilets, and staff were observed offering support

discreetly in order to maintain people's dignity.

However we also saw people's personal care and support records which contained a completed pen portrait and information about the person, their lifestyle, background and hobbies were not identified by their name, but just their room number. To see a person's name you had to completely open the folder. We also heard some staff when speaking with other staff refer to people by their room number and not their name. We saw several incidents where staff did not knock on a person's bedroom door before entering and a cleaner who was in a person's room using a very noisy cleaning machine, while the person was still in bed and not fully covered up.

We observed the majority of people were appropriately dressed with their hair brushed and their nails and teeth or dentures cleaned. We did notice a few people with food spills on their clothes that had not been changed.

The service operated a resident of the day scheme which meant approximately once a month people had the opportunity to ask the chef to prepare them a special meal and ask the activities coordinator to arrange a specific activity they enjoyed. It was clear from feedback we received from staff on one unit they knew who 'the resident of the day' was on the second day of our inspection and confirmed they had asked the chef to prepare them a dish that day which originated from their country of their birth. This was not the same for all the units.

The chef was aware of people's individual dietary needs and was able to cater for people with special diets due to their cultural and religious needs and wishes. For example, they knew who ate Halal meat or did not eat beef or pork on religious grounds. We also saw the cook routinely prepared culturally specific meals for people, such as Caribbean style rice and peas and salt fish and ackee. The chef gave us a good example of an African style soup they often made from okra for one person who had expressed a wish to eat this meal which reminded them of their childhood.

Visitors said there were not aware of any restrictions on times they could visit their relative, apart from one visitor who told us they were asked not visit during meal times. Protected meal times are sometimes used to help ensure people can eat in a quiet and relaxed atmosphere without outside distractions.

During our inspection we spoke with a person who told us they were waiting for transport to take them to see their family who lived nearby to have an evening meal with them. Staff told us they arranged transport for this person every week so they could spend quality time with their family at home, which was clearly important to this person.

There were a number of initiatives that had started on one of the units, for example, a pet therapy service had been started by the unit manager, which people liked and a Dementia Café which had been well received by people and their families. The unit were also looking for volunteers in order to provide a twice monthly special afternoon tea for people.

Requires Improvement

Is the service responsive?

Our findings

People and relatives said they had some involvement in the development of their care plans but were unsure when or how often these were updated. Care plans were written in a person centred way and focussed on the person's care needs, abilities and choices. They also included detailed information about how people preferred staff to deliver their personal care and who was important to them, such as close family members and friends.

People and relatives commented "They don't ask me enough about me and my life," "They do know about me because I tell them everything and make them laugh," "They could ask [my relative] more about her life, it's been quite interesting and it may help trigger memories or conversation for her" and "They know his needs well and I make sure I tell them everything but they don't have much time."

Care plans were reviewed regularly and updated as and when required if there had been changes to a person's needs and/or circumstances. Where changes were identified, information about this was shared with staff through shift handovers. However we also found that staff especially agency staff did not always know about any changes because they were not given the time to read the person's care plan.

Meadbank was responsive to meeting the cultural needs of people from different backgrounds, in particular, those residents who needed interpreting services. We saw there was information about local advocacy services. Staff were able to articulate how they would manage dealing with people who spoke different languages and staff told us that there was currently a resident who spoke a certain language and a staff member who spoke the same language who they had used as an interpreter. We were told that leaders from different religious orders visited the home either weekly or fortnightly and anyone was welcome to attend the services they conducted. That said we did not hear about what provision was made for people of a non-Christian faith that may like to share their faith in other ways.

We heard in the morning managers' meeting a discussion on the call bells (which people could use to get help from staff). These were audited and monitored by the clinical service manager. It was found that response times to call bells were getting better and that they followed up on call bells that had been left for more than 6 minutes, although there was one call bell response which was 20 minutes long.

Staff also explained people were moved around to meet their needs, for example a person who spent time in their room was moved from a small room to a larger room. Another person's television was also moved from a wall mounted position to the end of the person's bed as they found it difficult to watch the TV when it was mounted on the wall.

The home had three activities co-ordinators who were responsible for planning and implementing activities that people wanted or would perhaps like to try. The activities coordinators took the lead in supporting people to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. They told us how they discussed with people individually and in activities meetings what kind of activities they would like to do.

There was no external or internal support or training for the activities coordinators (for example, in communication, in setting out plans for other staff, in the therapeutic application of activities for people with dementia, or in supporting people with physical and sensory impairment). The activities coordinators we spoke with felt they would benefit from receiving some specialist training, especially with regards to supporting people living with dementia, as well as having more resources and equipment to improve the range and activities they could provide.

People told us they had opportunities to participate in social activities and one person said, "The staff do organise activities here. I personally like watching the old films." During our inspection we observed a game of dominoes in a communal lounge, a game of bingo being played, a sing-a-long, a film afternoon and people actively taking part in a television quiz show. The weekly activities timetable also included hairdressing as an activity twice a week.

We also observed throughout the day people watching television in the lounges or resting in their rooms. The activity records in people's care file had been completed as to what they had joined in with or not. These showed that the activities coordinators spent quite a bit of time with people who stayed in their rooms. This was confirmed by our observation.

The activities coordinators we spoke with expressed commitment and passion for the work they did. We recommend that training and access to other, external, examples of how activities in care homes work well would help professionalise the practice of activities coordinators as well as supporting their existing commitment and work.

The service had arrangements in place to respond to people's concerns and complaints. People and their relatives told us they knew how to make a complaint if they were not happy with the service provided at the home. People and relatives explained the type of complaints they had made and gave us examples of the responses they had or had not received. Comments included "They do listen to you but you have to wait to get things done," "Things get done but it takes lots of reminders," "It's like talking to wood" and "You don't often see the management around and I don't think I could just walk in to the office and speak to them."

CQC had also received a large number of complaints about the service from friends and relatives and although we do not investigate individual complaints we did look at the themes of the complaints at this inspection.

Meadbank did not have a central recording system for complaints. One very serious complaint was recorded as being escalated to stage two but no response or action was recorded as having been taken. Where complaints had been escalated to the safeguarding stage there was very little detail to indicate that a full and thorough investigation had taken place or any investigation at all. There were several complaints about one member of staff which again appeared not to have been investigated or replied to. Complaints submitted through the central BUPA system all had a response filed against the complaint. Another complaint was responded to the day after it was received, this was from a person staying in the private unit of Meadbank.

The inconsistent response to complaints received at the service constitutes a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's preferences in reference to their end of life care were respected and were recorded in people's care plans.

Inadequate

Is the service well-led?

Our findings

The provider did not have effective governance, assurance and auditing systems or processes in place to assess monitor and drive improvement in the quality and safety of the services provided. The provider did not have systems and processes to monitor and mitigate any risks relating the health, safety and welfare of people.

Although the provider had well established quality monitoring systems in place, which they referred to as their 'operational essentials plan', we found these arrangements had failed to pick up a number of issues we identified during our inspection.

We looked at the operational essentials plan which set out the daily, weekly, monthly and quarterly checks and reviews managers and senior staff working at the home should be routinely carrying out to ensure people living at Meadbank received good quality and safe care. This included daily walk rounds of the home by managers and a 'take 10' meeting which heads of department were expected to attend, as well regular audits of care plans and risk assessments, medicines management, infection control and food hygiene, health and safety, fire safety, laundry, service user involvement, activities, staff recruitment, training and supervision, staffing levels, and safeguarding incidents, complaints and accidents.

However, despite all the scheduled reviews and checks described above we found a number of issues during our inspection. This included a high percentage of staff not having up to date training in some key aspects of their role, a lack of staff supervision and appraisals meetings, a lack of team meetings and the variances in staffing levels. The poor hygiene and inadequate infection control measures we found, had not been found and addressed. The maintenance issues we found especially around the lack of action to eradicate the vermin infestation. The general maintenance issues, such as cleanliness, poor décor, appropriate checks on equipment and gaps in the homes health and safety checks. Action had not been taken to respond to people's concerns and complaints. Also positive action had not been taken to address the continuing safeguarding complaints.

The provider had also not sent us notification they are required to send in relation to safeguarding alerts and DoLS notification. The provider could not produce when asked records about the overall management of the regulated activity.

People and their relatives had opportunities to share their views about the home with managers. The service used a range of methods to gather stakeholder's views and involve them in the home's operation which included, quarterly resident and relatives meetings chaired by the registered manager and an annual customer satisfaction survey.

However, at the time of our inspection managers were unable to locate any satisfaction surveys customers had returned in the past 12 months or the survey action plan which the registered manager told us had been developed to address the issues raised as part of this feedback. After several times of asking we received the results of the 2017 survey which had 55 returns from residents although we have not seen an action plan

that we had asked for. The main reception area had a noticeboard with information for residents and relatives. One notice was entitled "You said, we did" and two changes were noted which were to "raise awareness of dementia" by starting a six-weekly dementia café; and "revamp reception" the reception had been painted and new furniture purchased and a dementia café had been started o one unit. This board was undated but we noticed the actions were different from when we last inspected in July 2017.

There were procedures in place for staff to raise concerns and report problems, and regular handovers between shifts meant it allowed issues to be raised. We observed one handover and noted that it took over an hour to complete. Whilst the unit manager was very thorough and detailed no one who was coming on the new shift took any notes. It was difficult to see how people would remember the content of the discussion. Day staff did not actively participate in sharing news or issues, although they were required to attend, because of this they left much later than their shift officially allowed.

We found that the home's current systems and processes had failed to identify shortfalls in areas of safety and effectiveness with regard to training and supervision of staff. The lack of a specialist dementia approach and dementia-friendly environment, together with no immediate evidence of specialist services for Alzheimer's, Parkinson's Disease or strokes, indicated that the home was not using quality audits and feedback in order to continuously improve the service it gave.

The contrast between the main parts of the home and the private units of the home indicated that the shortfalls were not the result of a lack of awareness of what was required.

Discussion with three ward managers exposed a highly varied management skill mix. No evidence seen highlighted that managers were given the opportunity to develop management skills or to share and reflect. The above paragraphs represent a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However we also saw some good examples of management and leadership. The home had systems in place to ensure visiting relatives and professionals identified themselves and signed in and out safely. The receptionist managed the constant flow of visitors and requests in a polite and professional manner. Each floor had a nurse in charge who was responsible for the quality of care provided. One nurse told us, "I love working here and I see my role as making sure I set the standard and set an example by applying it to myself. That way, I know my staff will continue work to this standard even when I am on leave."

The home encouraged people and visitors to provide feedback about the service and to make any suggestions they felt would improve the service. There were leaflets and forms available in reception area. The results of this feedback were not available. We saw the minutes of resident and relatives meetings which had been well attended. The registered manager told us they planned to increase the frequency these meetings were held from quarterly to monthly during 2018.

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 Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure the premises and equipment used by the service provider was clean, suitable for the purpose for which they are being used, and properly maintained. Regulation 15 1,(a)(c)(e) 2

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an appropriate system in place to receive, respond to, and act upon complaints.

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

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users receiving care or treatment and did not do all that is reasonably practicable to mitigate any such risks. They did not ensure that care and treatment was provided in a safe way for service users in terms of preventing, detecting and controlling the spread of infections. They did not ensure the proper and safe management of medicines. They did not assess the risk of, and prevent, detect and control the spread of, infections. Regulation 12, 1,2, (a)(b)(c)(d)(g)(h)(i)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not ensure that systems or processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided. They did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user or other records of the management of the regulated activity; Regulation 17 1,2,(a)(b)(c)(dii)(e)(f)

The enforcement action we took:

We issued a warning notice