Appollo Homes Limited

Meadow Dean

Inspection report

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11 May 2017
16 May 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 10, 11 and 16 May 2017 and was unannounced.

The service is registered to provide accommodation and personal care to 26 older people who may be living with dementia. On the ground floor, there are two communal lounges, a dining room and a small conservatory. Bedrooms are situated on the ground and first floor. The service is situated in a quiet picturesque area of River, Dover, with easy access to local shops. At the time of this inspection there were 21 people living at the service.

The service did not have a registered manager in post. We wrote to the registered provider about this before the inspection. The provider told us the manager was going to apply to be the registered manager, then told us that this would not now happen and they would recruit a manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager led the day-to-day running of the service and was supported by the provider. The manager was on holiday at the time of the inspection.

We last inspected Meadow Dean in November 2016 when four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. We issued requirement notices relating to the need for consent, safe care and treatment, good governance and staffing. There was an additional breach of the Care Quality Commission (Registration) Regulations 2009. We issued a requirement notice relating to notifications of other incidents as the provider had failed to notify CQC as required.

The service was rated 'Requires Improvement' and 'Inadequate' in the 'well-led' domain. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. The provider had not met the previous breaches of regulations and further breaches were found.

There was not enough staff to keep people safe. The manager had completed dependency assessments to work out how many staff were needed, but these did not show people's true levels of need. People who had a high level of need, for example, they required the assistance of two members of staff to assist them with moving, had been assessed as having a low level of need. Staffing levels were unsafe as a result. People's dignity was compromised due to the lack of staff. The lack of staff meant people had to wait up to twenty minutes to have their call bells answered. They were unable to go to the toilet when they wanted and had to wait to receive support. Staff were not always recruited safely.

People did not always receive their medicines as prescribed. Some people had not received medicine to help keep their bones healthy for over a month. Some people needed to take their medicine at the same

time each day to help them stay healthy and well. These medicines were given to people too late. One person needed to take medicine before they ate to stop them being sick and to ease their discomfort. Staff were unaware that this was the case and regularly gave the person their medicine after they had eaten.

Risks relating to people's care and support had not been adequately assessed and staff did not follow guidance from health care professionals. One person, at risk of choking, needed to have their drinks thickened to reduce this risk. Staff had run out of the person's prescribed drink thickener and had not ordered any more. The person's GP told us that a prescription for thickener had not been ordered since November 2016.We saw staff giving the person drinks that had not been thickened. . Staff did not follow Speech and Language Therapy advice when assisting this person to eat safely.

There had been occasions when people displayed behaviours that may challenge. There were no step by step guidelines in place to explain to staff how to support people in a way that suited them best. Some people required staff support to clean and change the filters in their oxygen machine weekly and the tubes every fortnight. This had not been completed for over a month.

Assessments of people's needs had not been completed when people moved into the service or returned from hospital. One person had returned from hospital and there had not been a full handover between staff. Their condition had deteriorated and they had been re-admitted to hospital as a result. Staff did not have access to the necessary guidance to ensure people could be moved from the service in the event of an emergency.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. These safeguards protect the rights of people using services by ensuring that if there were any restrictions to their freedom and liberty, these had been agreed by the local authority as being required to protect the person from harm. The provider had made one DoLS application; however, they told us this was due to 'the person's behaviour.' They did not understand that people's liberty was restricted if they were under continual supervision and unable to consent, and had not made DoLS applications as result to ensure this supervision was lawful.

Staff did not always treat people with respect. We observed staff moving a person sitting a wheelchair, without explaining what they were doing. The provider had made decisions on people's behalf, such as changing the access to the conservatory, without consulting with them.

There was a task orientated culture at the service, staff were busy doing different chores rather than spending time with people. Staff did not have the time to spend with people to give them person-centred care. Meal times were arranged around staff and not when people wanted to eat. There was not enough staff to engage people in activities. An entertainer was present on the afternoon of the first day of the inspection, and people enjoyed this, however, the rest of the time people sat in their rooms or the lounge in front of the television with no interaction from staff.

Staff had not received the training and supervision necessary to complete their roles effectively.

The premises were dirty and some people's rooms smelt of urine. Infection prevention and control procedures were not adequate. Staff had left soiled laundry on the ground in the garden on top of dirty but unsoiled laundry. Hazardous waste bins were unlocked and overflowing, which is against Department of Health guidance.

There was no registered manager in post, as required by the provider's registration. The provider did not

have a background in care and had not identified the serious concerns that we raised at this inspection.

The manager had informed CQC of any important events that occurred at the service, in line with current legislation. The manager of the service had raised safeguarding concerns. We asked the provider to inform the local safeguarding team of the concerns we identified. This happened on the second day of the inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.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.

There was not enough staff to keep people safe. The provider had not ensured that all staff were safe to work with vulnerable people.

People's medicines were not managed safely.

Risks to people had not always been assessed or mitigated.

Infection control procedures were not being implemented to reduce the risk of infection.

The manager had raised some safeguarding concerns.

Is the service effective?

Inadequate

The service was not effective.

People were not supported to eat or drink safely.

Guidance from healthcare professionals was not always recorded or followed.

The provider had not applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted, as required by law.

Staff did not receive the training or supervision to carry out their roles effectively.

Is the service caring?

Inadequate

The service was not caring.

People had to wait to receive support; this compromised their dignity.

Staff were rushed and did not always have time to be kind and caring.

The provider had made decisions on people's behalf, without consulting with them.

Is the service responsive?

Inadequate

The service was not responsive.

People had been admitted to the service without a full assessment of their needs being completed.

People were not able to participate in activities of their choosing.

There was a complaints procedure in place, However, complaints had not always been investigated and responded to fully.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in place. The provider did not have a background in care or understand how to support people safely.

The manager had completed some checks, but had not identified the serious issues we raised at this inspection. People's feedback had been sought but not always acted on.

There was a task orientated culture at the service. Staff did not have the time to spend with people to give them person-centred care.

Meadow Dean

Detailed findings

Background to this inspection

This inspection took place on 10, 11 and 16 May 2017 and was unannounced. The inspection was carried out by two inspectors on the first day and three inspectors on the second day. We returned to meet with the provider on 16 May 2017 to discuss our concerns regarding this service.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we inspected the service sooner than we had planned. Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with ten people using the service, six relatives, the provider and seven staff. We observed staff carrying out their duties, communicating and interacting with people. Some people were unable to tell us about their experience of care at the service so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at twelve people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

During our inspection, we spoke with local safeguarding and commissioning teams about the concerns we identified. They visited the service between 11 and 16 May and reported further issues.

We last inspected Meadow Dean in November 2016 when four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified and one breach of the Care Quality Commission (Registration) Regulations 2009. At this inspection, there were four continued breaches and three additional breaches of the regulations.

Inadequate

Is the service safe?

Our findings

At our previous inspection in November 2016 the provider had not ensured there were sufficient numbers of staff on duty at weekends to ensure that people's needs were fully met. The provider had no way of assessing how many staff were needed on each shift and no working rota to show which staff were covering for sickness or annual leave. At this inspection, the situation had deteriorated and there were not enough staff to keep people safe.

People and their relatives told us that there was not enough staff on each shift. One person told us, "There are more agency staff than girls. When I moved in it was lovely – now it's gone to pot."

One relative told us, "The staff are always rushing. There doesn't seem to be enough of them." Another relative said, "My relative told us that the service was short staffed, and the weekends were worse" and, "The staff group is not stable, some have left, agency staff are being used and new staff have been recruited so there have been lots of changes."

Staff told us that there were times when there were not enough staff on duty; they said it was very hard to manage with just two care staff on shift. Staff said that they did their best to make sure people received the care they needed but the lack of staff resulted in people having to wait. One staff member said, "There is just not enough staff."

On the first day of the inspection, the staff on duty were busy and rushed. They were not able to take a break in the morning, as they were so busy. The staff rota was not clear and did not always indicate who was on duty. Staff told us that they did not have a four weekly rota to confirm what shifts they were covering as the rota was written week to week giving them short notice of their shifts. The rota showed that some agency staff were being used and permanent staff were also covering vacancies and working excessive hours. Some staff had worked up to 70 hours in a week. The provider told us that this was the staff's choice but had not assessed the impact on staff and people of working excessive hours.

The manager had completed dependency assessments for each person living at the service to help determine the number of staff needed. People with high needs who required the assistance of two staff had been assessed as having a 'low dependency.' The dependency assessments did not accurately represent people's true level of need or the amount of support they needed from staff. Therefore, the dependency assessment was unreliable and there were insufficient staff on duty to meet people's needs.

Between 9am and 11am on the first day of the inspection, there were two care staff on duty for 20 people. Three people required two care staff to support them with their personal care and going to the bathroom. If one of these people needed support during this time then there was no other staff available to assist the remaining people. We asked the provider what happened if someone needed assistance during this time, and they told us, "I cannot answer that."

There were three care staff on duty between 11am and 9pm. However, the senior member of care staff was

required to prepare lunch for all 20 people. There were no kitchen assistants or cooks to assist with food preparation. When lunch was being prepared there were again only two care staff available to assist 20 people. We observed people having to wait up to twenty minutes to have their call bells answered when they needed assistance.

We asked the provider to ensure there would be more staff on duty going forward. They told us they would book additional agency staff and would confirm staffing levels via email. The local authority informed us on 12 May that they were concerned that there were only two members of care staff on duty. The provider did not email us confirmation of the service's staffing levels and was not present at the service at this time. The local authority stepped in and provided some staff to work at the service over the weekend to make sure people had the support they needed. We met with the provider and raised concerns about the staffing levels, the provider agreed to use more agency staff.

The provider had not ensured there were sufficient numbers of staff on duty to ensure that people's needs were fully met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our previous inspection, the provider did not have sufficient guidance in place to safely support people with their behaviour. Risk assessments for smoking and the use of oxygen were not detailed to show staff how to manage the risks safely. At this inspection, improvements had not been made.

There had been occasions when people displayed behaviours that may challenge. There was risk that they may hurt themselves or other people. This risk had not been assessed. There were no step by step guidelines in place to explain to staff how to support people in a way that suited them best. Staff told us that one person could be 'verbally aggressive' and there had been an incident on the first morning of the inspection. We asked to review this incident form and one had not been completed. Handover notes showed that the person had been 'verbally aggressive' because they 'had run out of cigarettes.' There was no information in the person's care plan regarding this behaviour or how to support them, and no information stating that running out of cigarettes could be a trigger for behaviour. Staff told us that this happened quite often, but that they, "usually just gave them one of our cigarettes." The two staff on shift that morning did not smoke, so there was no contingency in place to ensure the person remained calm and was able to smoke as they wished. After the inspection, a healthcare professional reported that the provider had still not supported this person to obtain cigarettes.

There was some guidance in place for staff regarding the management of people's oxygen. Two people required the filter in their oxygen machine to be changed and cleaned weekly and their oxygen tubes to be changed every two weeks. This ensured that they received the correct level at oxygen and reduced the risk of infection. There was a monitoring sheet for staff to complete when they had performed these tasks. One person had not had their oxygen filter changed or cleaned between 6 and 20 April 2017. They told us, "The [oxygen machine] filter has to be changed on a Friday. They [staff] don't all know when so I write it down and remind them." Staff had not changed and cleaned another person's oxygen filter or tubes since 17 April 2017. After we identified this, we asked staff to change and clean this person's oxygen filter and this was done on the first day of the inspection.

Risk assessments to support people with their mobility had guidance for staff to follow, however some people were living with Parkinson's disease and had suffered strokes but there was no details of how these medical conditions affected their ability to move safely. People also needed support to bath safely. The care plans stated the number of staff needed such as, 'one carer to help to get in and out of the bath,' but there was no further guidance in place to manage any risks when people were using the bath hoists to get in and

out of the bath.

The provider did not have sufficient guidance in place to safely support people with their behaviour or mobility. People's oxygen tubes and filters were not cleaned and changed as required. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our previous inspection, The provider did not have effective systems in place to prevent and control the risk of infections and to keep the service clean. At this inspection, improvements had not been made.

People's bedrooms had a sink; however, there was still no hand wash for people or staff to use in some bedrooms. There were limited amounts of hand wash in the bathrooms. Staff were unable to wash their hands on entering or leaving people's rooms, as recommended in the guidelines for good infection control.

There was a risk of cross contamination from soiled clothing and waste. There was a large amount of dirty laundry that had not been washed. This was placed on the ground in front of the washing machine, which was in a small shed in the garden. The garden was freely accessible by people. A large amount of laundry was in red bags, these bags are used when items have been soiled with body fluids and could be infectious. Yellow bins used to store clinical and soiled waste were left unlocked and were overflowing. They were stored in the garden which was freely accessible to people. Guidance from the Department of Health states that soiled waste bins should be locked to prevent cross contamination.

At the previous inspection, staff were using two mop heads, one for the bedrooms and one for the toilets and the mops were not being laundered daily. At this inspection, staff told us that the mop heads were only being laundered weekly and soaked overnight. Mop heads should be laundered frequently to reduce the risk of infection. Current guidance also states that there should be separate mops for different areas of the service.

At our previous inspection, the provider was not ensuring that the premises were safe. A fire door was bolted and in need of repair. We advised the provider to seek advice from the Kent Fire and Rescue Service with regard to the safety and effectiveness of the fire door. The provider told us that the Fire and Rescue Service had now visited the service and told them that the door was safe. There was no record of this visit available at the inspection. We contacted the Fire and Rescue Service who confirmed they had not visited the service, but would arrange to visit the service to ensure people were safe.

There was a risk that people would not receive the assistance they needed in an emergency such as a fire. People had personal emergency evacuation plans (PEEPs) in place. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of an emergency. However, PEEPs were stored in a file locked in the provider's office, which was inaccessible when they were not there.

Agency staff had asked about arrangements for fire at the start of their shifts and told us this information was unavailable because it had been locked in the office. They did not know what to do if an emergency occurred. One person told us, "My wheelchair won't go through the door because it's too wide." We checked and confirmed the wheelchair would not fit through the door with the person sitting inside it. The person's PEEP stated that staff should evacuate them using their wheelchair, and no consideration had been made as to how to assist the person to leave the service safely. We spoke with the provider about the importance of all staff knowing how to evacuate people safely. The information about safe evacuation was removed from the locked office. The provider told us they would review people's PEEPS to ensure there was accurate guidance on how to help everyone leave the service safely.

There were now updated environmental risk assessments in place; however, these were generic and not specific to the service. For example, there was no mention of specific risks such as the steep incline on the disabled access ramp to the garden or the multiple stairs in the building.

The cupboard containing cleaning materials was left unlocked when the domestic member of staff was elsewhere cleaning the service. This was an unsafe practice as the cupboard was situated where anyone could access the cleaning materials. We asked the provider to immediately lock this cupboard. The local authority reported that their staff had found the cupboard unlocked again on Saturday 13 May 2017. We told the provider that this cupboard must be kept locked to keep people safe.

The provider had a plan in place to improve the premises; however, there were no timescales as to when the work would be completed. There were areas of the premises which were in need of repair, such as the windows, and the front door. The front door was not sealed and had a gap at the bottom where daylight shone through.

The provider had not ensured that the premises were safe and that people would be able to leave the service safely in an emergency. The provider did not have effective systems in place to prevent and control the risk of infections. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff carried out regular maintenance checks on systems like the electrics and gas supply. The hoists which were used to support people to mobilise had been serviced to make sure they were in good working order. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working. The yearly portable appliance electric testing was due to be carried out in May 2017 but this had not been arranged at the time of the inspection.

People did not always receive their medicines safely. Staff did not always give people their medicines in line with the prescribed instructions on their medicines administration records (MAR), as instructed by people's doctors. One person was prescribed two medicines to be administered before they ate. This was to stop them being sick and to ease their discomfort when eating. On the first day of the inspection, they were given this medicine at 2:30pm, after they had eaten their lunch. We spoke to two members of staff who administered medicine. They both told us there was 'an hour window' to administer this person's medicine and it did not matter if it was administered after they had eaten. We showed them the person's MAR and they agreed that the medicine should be administered before the person ate, but they had been 'unaware' of this.

Five people were prescribed medicines to be administered weekly to help keep their bones healthy. Three people's MARs were unsigned for this medicine since the 17 April. There were four tablets for each of these people in stock, indicating that this medicine had not been administered during this time.

People's lunch time medicines were scheduled to be administered at 1pm. Two people were prescribed medicine to control the level of dopamine in their brain. It was important these medicines were given at the same time each day to ensure the dopamine levels remained constant. On the first day of the inspection, people did not start to receive their lunch time medicines until 2pm. One person received their medicine at 2:10pm and another person received their medicines at 2:18pm. There was a risk their dopamine levels could have dropped as their medicine had been administered too late.

Staff had handwritten one person's MAR. The dates on this record had been written incorrectly. Staff had written they had administered two different medicines on 31 April, even though this date does not exist. The

MAR ran out on the 9 May and staff had not started a new sheet. There were 22 instances in the past month where staff had not signed the person's MAR to confirm they had administered their medicines. We checked the stock of medicines with staff and it appeared the person had received their medicines, but the lack of recording and the additional, incorrect dates meant there was a risk these may have been administered incorrectly. Handwritten MARs had not been double signed by staff to confirm they were completed correctly and checked. This was highlighted as an area for improvement at the last inspection.

People were not always receiving their medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed special drugs that needed to be counted and checked by two members of staff every time they were given to a person. All these types of medicines were given to people safely and procedures had been followed.

Staff recognised different types of abuse and told us that they would report any concerns to the manager. They were aware that the local authority would investigate concerns if required. The manager had contacted the local authority in line with safeguarding protocols when concerns had been raised and was working with them to address the issues. At the time of the inspection, we identified that some people were at risk of harm and the provider took some actions to address this. We told the provider to speak with the local authority to raise these concerns and this was actioned on the second day of the inspection.

People's finances were recorded and processed by the manager with no other member of staff having access to this system. We checked the records held for five people's monies and found that four of them were incorrect. The provider did not audit these records and although people had capacity to sign for their monies, only the manager signed the records.

At our last inspection in November 2016, we highlighted that one staff member's criminal background check had not been updated since 2000. There was also a lack of references for all staff to confirm their conduct in their previous employment. At this inspection, some staff files did not contain the required information to confirm the necessary checks had been carried out to ensure that staff were safe and suitable to work at the service. The provider told us that they were in the process of auditing the files to take the action required. Some long established staff did not have a Disclosure and Barring Service (DBS) criminal records check in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services

The provider told us that they were going to apply for the DBS checks in the near future but there was no evidence that these had been applied for.

The provider had failed to carry out the relevant recruitment checks to ensure that staff were suitable to work at the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service effective?

Our findings

People were not supported to eat and drink safely. There was a risk that people were not protected from avoidable harm as they were being exposed to significant risks of choking. A Speech and Language Therapist (SALT) had assessed one person as requiring thickened drinks of 'syrup like consistency' and a 'soft diet.' to avoid choking. On the first day of the inspection we found an unthickened drink in the person's bedroom. Staff confirmed that this was the person's drink, and it was unthickened, but they 'did not know who had made it.' We asked to see the person's thickener and there was none available at the service. The provider contacted the person's doctor and they confirmed thickener had last been prescribed to the service on 5 November 2016. Staff had not kept records of when the person was given a drink or the consistency of the drinks provided so it was possible that the person had been receiving un thickened drinks for some time, increasing the risk of choking. .

On the second day of the inspection we observed staff giving the person an unthickened drink. We intervened and, although there was guidance on the person's prescribed thickener and in a small kitchenette where drinks were made about how to make drinks of the correct consistency, the member of staff said they did not know how to do this.

There was no guidance available at the service about what the person's 'soft diet' should consist of and staff disagreed on what the person could and could not eat. One member of staff told us they regularly gave the person biscuits and another member of staff said that biscuits were not suitable. The provider told us that the person should be offered mashed potato instead of roast potatoes and the senior member of staff disagreed.

We raised our concerns with the local safeguarding team and community nurses visited the person the day after the inspection to ensure they were eating and drinking safely. The community nursing team provided us with a letter from the Speech and Language therapist (SALT) that had been sent to the service in February 2017. This letter recommended the person should sit, 'upright for oral intake, preferably sitting at a table' be, 'supervised to ensure they eat and drinks more slowly' and 'avoid any chewy textures and if possible cut food up into bite size pieces.' On the first day of the inspection the person was served liver and bacon with roast potatoes in their bedroom. They were handed the plate and staff then left the room to find them a table to put their meal on. The person placed a whole roast potato in their mouth and ate it. The liver and bacon was not cut up. They were not supervised at any point when eating.

The manager had updated the person's care plan on 3 March 2017 and written, 'Eats alone SALT team added thickener and soft diet now better.' There was no guidance available to tell staff the person should be supervised, sitting at a table and that their food should be cut into bite size pieces. The person's care dependency needs assessment for eating and drinking dated 29 April 2017 stated that they managed their food unaided and that they did not need any support with their eating and drinking. This assessment had not taken into account the recommendations made by the SALT team to ensure that they ate safely.

People were not always supported to eat and drink safely. This was a breach of Regulation 12 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that their vegetables 'turn up' cold sometimes and 'had been undercooked.' One person said they were not happy as the meals were not served hot, they said, "I would not say my lunch is served in any way hot, this happens on most days." Another person said, "One day they gave us one sausage for tea, I said that this was not enough so from now on we have two."

The service had a dining room with tables and chairs, however on both days of the inspection people ate at their tables in the lounge, whilst others ate alone in their bedrooms. The provider told us that people choose not to use the dining room but we did not see staff ask anyone if they wanted to go into the dining room to eat. Staff just laid people's individual tables in the lounge without mentioning or asking people if they would like to go in the dining room. One person said they were not happy as they had to buy their own salad cream and salad dressing. Two people requested condiments with their meals whilst others just ate their meals without them.

People did not always receive the support they needed to manage their health care needs. One person told us they had been asking staff for laxatives for several days as they were constipated. Staff confirmed the person had requested this, however they had not taken any action. Staff arranged for the person to have laxatives delivered and administered after we asked them to do so.

People had access to health care professionals such as community nurses, occupational therapists, the SALT team, dentist, chiropodist and optician when required. However, their guidance was not always documented and followed. One person returned from hospital on the second day of the inspection. They were living with diabetes and needed regular insulin injections to keep their blood sugar levels within a safe range. Staff had not arranged for them to receive their insulin as prescribed.

One person's care plan stated that they had developed a pressure area, their care plan stated that the person refused to have bed rest to relieve the pressure and had refused to use pressure relieving equipment. It was noted that staff had contacted the community nurse who had said to log this refusal. The care plan stated, 'to encourage the person to walk during the day to help maintain their mobility and improve their skin condition, also standing and sitting exercises,' there was no further information as to what the exercises entailed, no details to guide staff how to manage the pressure area or how to encourage the person to use the equipment to reduce the risk of the pressure area getting worse.

The provider had failed to ensure that people received safe support with their healthcare needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008.

At our previous inspection, the provider had failed to assess people's mental capacity to make specific decisions and apply for authorisations to deprive people of their liberty, when required, in line with the Mental Capacity Act. At this inspection, this remained the case as the mental capacity assessment forms were generic and did not cover individual decisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider had not followed the principles of the MCA and had imposed restrictions without ensuring the lease restrictive option was used and without giving regard to people's capacity to consent to the restrictions. The provider told us that they had made one DoLS application since our last inspection. However, there were other people living with dementia, under constant supervision and unable to leave the service where DoLS applications had not been considered. The provider told us that they had received MCA and DoLS training; however, they did not have an understanding of when it would be necessary to make a DoLS application or what it involved.

Some people had made advanced decisions and 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decision in place. One form did not have the correct address on and a yellow sticker was attached to the form stating it needed to be updated. This had not been actioned and there was a risk that this decision would not be acted on, as the information was incorrect.

There were contradictions in people's care plans regarding their capacity to make decisions. People had signed to confirm their consent to the care detailed in their care plans. One person was assessed as having full capacity had signed but so had their relative which indicated that they did not have full capacity to consent to their care. Another person was deemed as having full capacity yet their DNACPR stated that they lacked capacity. Not all staff had attended training about the MCA and lacked awareness when we asked them about the MCA.

The provider has failed to ensure that staff were working within the principles of the Mental Capacity Act (2005), as applications to deprive people of their liberty had not been applied for when needed. This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

In some cases, people's decisions had been respected. A person, who had full capacity, had made a decision not to have a minor operation. This decision had been respected and was recorded in their care plan.

The staff training matrix was not up to date. The manager told us that when staff had completed training the certificates had not been sent to the service, therefore the training matrix had not been updated. New staff had not been added to the matrix to confirm what training they had attended.

There were a total of eleven members of staff, including the manager. Staff had not all received training in basic, essential subjects such as safeguarding, fire safety and first aid. Staff had not received training in people's individual needs. Some people were living with dementia, Parkinson's disease and diabetes and there had been no training on these conditions or how they may affect people and their care needs. Staff had not arranged for one person living with diabetes to receive their necessary insulin injections when they were discharged from hospital. Staff had not received training in behaviour that challenged. Staff had not responded effectively when one person became distressed when they wanted a cigarette.

New staff told us that they shadowed established staff until they were confident to provide care on their own. There was a new senior staff on duty at the time of the inspection but they had not received an induction from the provider or manager. We asked them how they were co-ordinating the shift and they told us they were, 'going to see how it went.' They had not considered the direction staff may need or the support people may need throughout the shift. Agency staff did not receive an induction into the service and were not told essential information about people, such as how to support them to leave the service safely in an

emergency.

Two other members of staff had recently started at the service. On the second day of the inspection one staff member was shadowing more experienced staff. However, the provider was not supporting people to undertake an induction training programme linked to the Care Certificate, which had been introduced nationally to help new care staff develop their skills, knowledge values and behaviours. Staff told us that their training was up to date but records did not confirm this.

Staff did not have the necessary skills, training or support to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People told us that staff were busy and were not always able to be kind and caring as a result. One person said, "Some staff won't put themselves out. I could do with a kind word."

People had to wait to use the toilet and receive assistance. This impacted on their dignity. On the first day of the inspection we found one person in their room distressed, shouting, "Help me, help me, I have wet myself" and sitting on a commode. They were unable to reach and press their call bell, which was on the wall, so we pressed it for them. We waited with the person for five minutes until staff arrived. The person became more distressed throughout the five minutes and we held their hand. They were crying and asking us to do something. We did not want to leave them on the commode unaccompanied but there was no staff available to help. After staff had assisted the person, they told us that, "[The person] should not have got out of bed without telling staff first." The person had previously fallen in their bedroom when they had got out bed and had been unable to alert staff. No consideration had been given to ways of preventing this from happening again or the distress the person had been in whilst waiting for staff to arrive.

People told they regularly had to wait for staff to support them. Relatives told us that sometimes people had to wait to go to the bathroom and people would often ask them if they could take them. One person was getting upset and we asked if we could help, they said they always had to wait, repeating 'wait, wait, wait,' several times. People told us they had to wait for the bathroom, for their lunch and when they wanted to go to their bedroom.

Staff did not always treat people with respect. Staff entered people's bedrooms without knocking first or letting them know that they were there. We observed that a member of staff moved a person in a way that did not respect their dignity. The staff member moved the person's wheelchair backwards without any word to the person to let them know they were going to move.

During a music session, which people were visibly enjoying, a member of agency staff said, "This music is doing my head in." They said this as they walked through the main lounge, where many people were sitting and everyone could hear.

The provider made decisions on people's behalf without consulting with them or their relatives. There was a large conservatory at the service which overlooked the garden. At our previous inspection people had enjoyed sitting in this room and looking out at the garden. The conservatory had been turned into a room for staff. Comfy chairs for people to sit on had been removed and there was now a desk and office chairs for staff to sit on instead. The provider had made the changes to the room without asking people or their relatives their views. People told us they liked to sit in the conservatory in the sun and missed being able to do so. One person decided they would eat their lunch at the desk in the conservatory and remained there for a long time during the inspection. One person commented, "The conservatory used to be my favourite spot."

Relatives told us that the main lounge was a little crowded and they could not have a private conversation

with their loved one when they visited. The restricted use of the conservatory had resulted in more people sitting in this area. There was no private space (apart from people's bedrooms) available for families to have some privacy. One relative said, "It's a shame but people sit so closely together it is hard to have a private conversation." One person used their mobile phone in the lounge to speak with their relative. Everyone could hear their conversation as they chatted.

When we spoke with staff some of them did not know people's names or who people were. We asked staff questions about people and their needs and some staff told us, "I don't know, it is the first time I have been here. I don't know who people are."

People's care plans were stored in an unlocked cupboard in the conservatory. Throughout the inspection, care plans had fallen out of this cupboard and were on the floor, as the doors did not close properly. The conservatory door did not lock, which meant that people's confidential information was accessible to everyone.

People were not always treated with respect or dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Staff were too busy trying to meet people's basic care needs and answering people's call bells and did not have time to provide person centred care. They were not responsive to people's needs. One person told us, "I get a lot of 'I'll be back in a minute' and they never come back." Another person said, "Sometimes I have to wait quite a while for the staff to come." We observed people having to wait to have their call bells answered or to go outside if they wanted some fresh air or a cigarette.

Mealtimes were arranged around staff and not people. On the second day of the inspection, breakfast had not been served by 9 o'clock when we arrived at the service. People told us they were waiting for their breakfast and were getting hungry. Staff told us breakfast was 'delayed' due to a staff member's personal commitments making them late for work. They told us that this happened regularly and they were unable to know in advance when it might occur. No alternative arrangements were made to ensure people received their breakfast when they got up or wanted to eat it.

People were left waiting for their lunch on both days of the inspection. On the first day of the inspection, lunch was not served until 1:40pm and on the second day of the inspection lunch was not served until 2 pm. People told us they were unhappy about the timings of their meals. One person said, "It's dreadful, absolutely dreadful. Don't get me started; we will be having it for supper at this rate. It happens all the time." Another person said, "We haven't had lunch yet. I thought we had been forgotten."

People told us that the food had recently changed and people now received re-heated pre-prepared meals. The provider had consulted with people regarding this and offered people and their relatives an opportunity to try the food before it was introduced. However, some people told us they did not like the change. One person said, "The food used to be lovely. I don't know what they are doing." People had fed-back to the provider that they missed having a cooked breakfast. This was documented in a recent resident's meeting. However, staff and people confirmed that this request had not been acted on and they were still not able to have a cooked breakfast when they wanted.

The menu for the day was written on a board in the dining room so people were aware what was available to eat that day. However, on the second day of the inspection this board had not been updated. Staff told us that they were aware that it was incorrect, but did not update it at any point during the day. Staff did ask people individually to choose between two different options at lunch and dinner.

One relative asked staff where their loved one's walking stick was, as they had lost it. Staff told the relative to look in the sluice room as a number of sticks were stored there and they could take one of those. Staff did not look to see if the person's stick was stored in the sluice room or ensure that the sticks available were suitable for the person to use. The relative told us they had recognised their relative's walking stick and ensured they received the correct one. A relative said, "Things go missing in the service, one time my relatives remote control was lost."

People were not supported to take part in activities of their choosing. A musician regularly attended the

service, and was present on the first day of the inspection. There was also a regular bingo session and people occasionally watched dog racing on television. There was no dedicated activities co-ordinator to support people to follow activities and hobbies of their choice. People's hobbies and interests were recorded in their care plans but there was no evidence that they were being carried out. People were not engaged in any activities on the mornings of the three days we visited the service. The current staffing levels were not sufficient to support people with activities; staff were busy doing other things like preparing people's meals. People slept, or were seated in front of the television, with little engagement from staff the rest of the time. Staff were too busy to stop and talk with people or spend time with them. Relatives commented on the lack of activities, one relative said, "There doesn't seem to be a lot going on most days, people are sat so close together in the lounge, it is difficult to move."

Before coming to live at the service, or being re-admitted from hospital, a pre-admission assessment of people's care needs should be completed by the provider to ensure that the service would be able to meet the person's needs. However, on two recent occasions no assessment had been carried out. One person had recently returned from hospital without the manager carrying out a care needs assessment. This person arrived back from the hospital in the evening, deteriorated over the next few days, and was re-admitted to hospital, as the service could no longer meet their needs. Another person had been admitted to the service for short period of time, without an assessment of their needs. There was no pre-assessment so staff would not know how to care for this person and meet their needs. A relative said, "I just spoke with the manager and my relative was admitted."

Some care plans were detailed and personal, and recorded people's preferences and choices, such as how many pillows they preferred and how they liked blankets instead of a duvet. Details included what time people wanted to get up and that they liked to wash their hands and face. However, other care plans stated, 'assistance from one care staff to help them wash and dress', with no explanation of what 'assistance meant to that person

Another person's care plan stated that they became anxious and staff should make them a cup of tea and sit for a chat. Staff told us they were busy and throughout the inspection did not have time to stop and talk to people. We could not be assured that this would happen, as there was not sufficient staff on duty for this to be carried out.

The information in care plans for people living with diabetes varied, in one care plan there were clear guidelines for staff to follow with regard to monitoring the condition, such as the range of 'normal' levels blood sugars may fall or rise and what symptoms to look for if the person needed medical assistance. However, in another care plan there was no range of 'normal' blood sugars for the person and no record of symptoms or what food or drink people liked to boost their sugar levels if required. We asked staff what they would do boost people's blood sugar levels and they did not know.

People did not receive a care needs assessment before coming to live at the service and did not receive person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured their concerns and complaints would be investigated and resolved. There was a system in place to respond to complaints. One complaint had been made since the last inspection. Although the complaint had been documented, there was no record that this had been investigated or responded to. The provider told us that the manager had looked into this and we asked them to send us this information after the inspection, but we did not receive it.

The provider had not kept an accurate, complete and contemporaneous record of all actions and investigations taken when dealing with complaints. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People and staff were complimentary about the manager. People said, "[The manager] was good." Staff commented, "[The manager] works really hard and always put people first". "We work well as a team and communication is good."

At the time of the inspection, the provider was in day to day charge of the service. This was because the manager was on annual leave. The provider told us that they had support from a consultant who visited the service on a monthly basis and the manager had handed over to the senior member of staff who was able to support the service in the manager's absence. During the inspection, the provider was unable to answer some of our questions and we were not able to gather all the evidence we needed. We asked the provider to supply this information after the inspection. Some information, such as evidence of lift and hoist servicing was sent but they were unable to provide evidence of investigation into a complaint and of staff training.

The service did not have a registered manager in post at this inspection. It was a condition of the provider's registration to have a registered manager. The previous manager left in August 2016. The provider told us that they had interviewed candidates, but felt that they had not been right for the service. In the meantime, a manager was overseeing the day to day running of the service with support from the provider. At the beginning of the inspection, the provider told us the manager was applying to be registered manager of the service, but no application had been received. After the inspection the provider told us that they not going to proceed with this application.

We last inspected Meadow Dean in November 2016 when four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. We issued requirement notices relating to need for consent, safe care and treatment, good governance and staffing. There was an additional breach of the Care Quality Commission (Registration) Regulations 2009. We issued a requirement notice relating to notifications of other incidents because the provider had failed to notify the Commission of some incidents.

The service was rated 'Requires Improvement' and 'Inadequate' in the 'well-led' domain. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches

The action plan stated that the service would be compliant by the end of February 2017; however, only one breach had been met with four breaches of regulations continuing. There were breaches found of a further three regulations.

At the last inspection in November 2016, we asked the provider to take action to ensure that suitable systems and procedures were in place in order to assess, monitor and drive improvement in the quality and safety of the service. Following the inspection the provider sent us an action plan to tell us of the improvements they were going to make. Improvements had been made with regard to implementing the checks and audits of the service; however, these were still not effective, as they did not pick up the serious shortfalls found at this inspection. The provider visited the service weekly; however, they did not undertake

any formal written checks on the work the manager was completing. The provider had employed a consultant who was advising them on the running of the home. The consultant told us they visited the service monthly and provided a report to the manager after each quality assurance visit, however we did not see the latest report at the time of the inspection.

People's finances were recorded and processed by the manager with no other member of staff having access to this system. We checked the records held for five people's monies and found that four of them were incorrect. The provider did not audit these records and although people had capacity to sign for their monies, only the manager signed the records.

Records were not always accurate and up to date. Dependency charts about people's needs had been completed incorrectly and did not fully represent people's needs. The number of staff on shift was not safe as a result. Guidance from health care professionals relating to the support people needed to eat and drink safely was not available and so was not being followed by staff. This meant people did not receive the support they needed, leaving them at risk of choking. People's medicines records were not completed accurately and they did not always receive their medicines as they were prescribed.

The provider had asked for feedback from people, their relatives and other stakeholders. However, people's views were not always acted on. As part of the quality assurance process, people had been asked their views about the food. One person had commented that the breakfast was poor; the provider went through what was available for breakfast such as cereals and a cooked breakfast every two weeks. People told us that they did not have cooked breakfast and this was not happening. The provider had changed the use of the conservatory so people were no longer able to sit in it, without asking if they enjoyed sitting there.

The systems in place to assess, monitor and drive improvement in the quality and safety of the service were not effective. The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each service user. The provider had failed to seek and act on feedback from relevant persons. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the second day of the inspection, we asked the provider to email us with assurances regarding staffing levels and information about how they were mitigating the risks we identified. The local authority informed us that there were still concerns regarding staffing levels and we made multiple attempts to contact the provider. The provider did not respond to us in a timely way, and the staffing levels at the service were not immediately addressed. This left people at risk. The local authority provided staff over the weekend to ensure people were safe. We met with the provider and they assured us and provided evidence that there would be safer staffing levels going forward.

The provider lacked the knowledge and understanding required to lead the service effectively. They told us they had completed training in the Mental Capacity Act and Deprivation of Liberty safeguards, however did not understand the implications of this legislation or that people's liberty was restricted within the service. The provider did not have a background in care or any care qualifications. They did not participate in any local events or forums to increase their knowledge or learn about best practice. There was no registered manager in place to provide this essential knowledge base or lead staff.

Staff did not have a full understanding of their responsibilities. When we highlighted serious concerns regarding people's medicines or their thickener there was a lack of understanding as to why these were risks to people. There was a limited handover when new staff came on shift and staff told us they were not given

direction to ensure that people received the care they needed. The provider told us they had never sat in on a handover so were unaware about what they contained.

The rating was not displayed at the service on the first day of the inspection, as required by law. We spoke with the provider about this and a poor quality colour print out of the front page of the inspection report was put up on a notice board in the entrance hall. The provider told us that the rating had previously been displayed, but had been removed when the entrance hall had been re painted. The registration certificated displayed in the entrance hall was out of date and included the name of the old registered manager.

At the previous inspection, we highlighted that staff had told us they could not access the main office as this was locked when the management staff were not on duty. Staff had told us, "There is no photocopier in the (general) office and this does restrict our work when we need to copy information or prescriptions". The provider told us that the office was in the process of moving and this would be addressed. However, at this inspection we found that no improvements had been made. Staff were unable to access the main office, where information regarding people's emergency evacuation plans were stored and were unable to use the photocopier. We had also highlighted that staff meeting minutes of did not show that issues raised had been dealt or followed through to confirm appropriate action had been taken. The provider had not taken action to rectify this.

There was a task orientated culture at the service. Staff did not have the time to spend with people to give them person-centred care. People had to wait to receive their meals, receive assistance with personal care or to go outside for a cigarette. Activities rarely occurred, and people spent most of the day sitting in their rooms or the lounge watching television. People's views and feedback were not always sought and they were no longer able to access the conservatory, even though they told us they had enjoyed sitting there. People did not receive a cooked breakfast even though they had requested one.

The manager had notified the Care Quality Commission of important events as required.