Coseley Systems Limited

Meadow Lodge Care Home

Inspection report

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Date of inspection visit:
30 November 2017
01 December 2017

Date of publication:
21 March 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced comprehensive inspection of Meadow Lodge Care Home on 30 November and 01 December 2017. At our previous inspection undertaken on 20 and 21 June 2017 the provider was found to be in breach of Regulations 11,12,14,16 and 17. We served a Warning Notice in relation to Good Governance and asked the provider to complete an action plan to show us what they would do, and by when, to improve the quality and safety of service people received. This action plan was received by us within the requested time frame.

At our most recent inspection we found that improvements had been made in relation to Regulations 11 and 14, but no improvements had been made in relation to Regulations 12 and 16. The regulation specified in the Warning Notice had not been met. During our most recent inspection we also found a breach of Regulation 9, Person Centred Care.

Meadow Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Meadow Lodge is a care home without nursing that can accommodate up to 22 people. At the time of our inspection 19 people were living at Meadow Lodge, some people lived there long term and others lived there for short periods of time such as respite care. This included a number of people who lived with dementia.

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. Meadow Lodge did not have a registered manager in post when we inspected. An acting manager had been appointed but they were not available to us throughout the inspection. During the inspection process the inspection team were supported by the provider and senior care staff.

People were not safe. Although people and relatives said they felt the service was safe, we found risks to people were not managed well and not always known or clearly understood by staff. Risks to people were not consistently assessed and therefore people were not kept safe from the risk of harm. Recording of these risks was not always evident, and in some cases the recording had not been reviewed as needed to reflect changes in people's care needs. People were not kept safe from risks associated with some aspects of the environment. People did not have access to a safe open space. Risk assessments were not in place to support people to safely access the garden.

People were put at risk of increased infection as facilities and systems were not available for staff to maintain good hygiene People were put at risk due to poor prevention and control of infection. Bathrooms and communal areas were dirty. Medicines management had improved since our last inspection but there remained some areas of concern relating to 'as required' medication and when and how people were supported to receive pain relieving medicines.

Staff did not have time to spend with people, although we found that there were sufficient staff to meet people's immediate needs. Staff operated a task based approach to care. The provider operated a safe recruitment system. Staff understood their responsibility to raise concerns regarding potential abuse.

The provider had failed to ensure staff had the training or knowledge they needed to undertake their roles safely and appropriately. We found that whilst training had taken place, there were significant gaps in staff knowledge about current good practice. Some staff did not feel supported and the provider told us that supervisions of staff had not been consistently offered. We found that staff understood they needed to offer people choices and gain their consent but people told us this did not consistently happen. We found that people's wishes in relation to being resuscitated or not, had been taken into consideration, but the process for doing so was not robust.

Some improvements had been made in relation to how people's nutritional needs were met, but several people told us they did not like the food. The provider had failed to ensure robust monitoring of people's food and fluid intake. People told us they did not have many choices of food. We found that people were given food but not encouraged or supported to eat it in all cases. We looked at the menus and saw that there was a variety of foods, but people told us they did not enjoy it. People did not have sufficient access to drinks that met their preferences. The provider had failed to adequately explore ways of making the home more dementia friendly. People had access to health professionals when their health needs changed, however the provider's systems could not assure us that all people's healthcare needs were met well.

People were not supported in a consistently caring manner. Staff did not always support people in a dignified way and people's rights to privacy were not always respected by the staff. People's independence was not actively promoted. Staff did not have time to build meaningful relationships with people.

People did not always receive care that was responsive to their individual needs. People's care was not person centred and did not reflect their preferences or meet their needs. People were not supported to follow their interests or participate in meaningful activities. The environment of Meadow Lodge was not suitable for all people who lived there. Community relationships had not been maintained or developed. The service had not implemented accessible information to an acceptable standard. We found that people at the end of their life did not have their needs reassessed as their needs changed. We found that equipment needed to support people's comfort and well-being was not always provided in good time.

The complaints process at Meadow Lodge did not meet people's needs and did not support people to have their voices heard. The provider had failed to investigate complaints or respond appropriately to people's concerns.

Systems used to monitor the quality of the home were not effective at identifying concerns and protecting people from risks to their health, safety and well-being. The governance system at the time of our inspection was not robust and in most areas it was ineffective. There had been very little improvement in the quality of the service or actions taken by the provider to mitigate risks.

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, it 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.

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

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Infection control arrangements were not effective and the home was dirty. Staff did not understand their responsibilities to keep the premises safe.

People's risk management was poor and people were at risk of accidents and adverse incidents that could be avoided. Risks to people were not reviewed as their needs changed.

People's medicines were mostly administered safely but 'as required' medication was not safely administered.

People were supported by sufficient staff to support them with basic tasks, but staff did not have time to spend with people.

Staff were recruited safely.

Is the service effective?

Inadequate

The service was not effective.

Staff received basic training but did not have sufficient skills and knowledge to support the people they cared for.

Many people did not like the food they were offered and did not feel there was enough variety.

Staff did not feel supported by the management team and did not receive regular supervisions.

People did not have access to a safe outside space.

Is the service caring?

Inadequate

The service was not consistently caring.

People's privacy was not maintained in all cases.

People did not always receive dignified care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was person centred or met their individual needs.

People had access to a complaints system but it was not effective in listening to people's concerns.

End of life care was not well managed and staff did not have the skills or knowledge to do this well.

Is the service well-led?

Inadequate

The service was not well led.

People lived in a service that had not been 'Good' for many years and the provider had failed to improve.

There were systematic and widespread failings in the oversight and monitoring of the service.

People were subject to risks that had not been mitigated.

There was no effective method of driving improvements within the home.

There was no culture of learning or developing within the management of the service.

Meadow Lodge 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 checked 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.

Following the last inspection, we asked the provider to complete an action plan to show us what they would do and by when to improve the quality and safety of service.

This inspection took place on 30 November 2017 and 01 December 2017 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, with an area of expertise in dementia care.

As part of planning the inspection we checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We also looked at any information that had been sent to us by the commissioners of the service and Healthwatch. We used this information to plan what areas we were going to focus on during our inspection visit.

We spoke with nine people, five relatives and three health care professionals at Meadow Lodge. After the inspection we spoke on the phone to a further two health care professionals. During the inspection we spoke with the provider and seven staff who worked at Meadow Lodge. We used the Short Observational Framework for Inspection (SOFI), SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also looked at care records, including pathway tracking two people. We spent time reviewing records that included rotas, training and supervision lists, staff recruitment files and audits.

Inadequate

Is the service safe?

Our findings

At our previous inspection of this service on 20 and 21 June 2017, we found the key area of 'Safe' to Require Improvement. The concerns were identified as a breach of Regulation 12 and were in relation to the unsafe management of medicines and poor risk management of risks associated with people's care and support. At this inspection we found that sufficient and timely improvements had not been made in relation to risk management and, in addition, serious concerns were found in relation to infection control. The service remains in breach of Regulation 12. We found that the service was now Inadequate in this key area.

We saw that risk assessments had been completed for some people, but this had not been done consistently. We reviewed care plans and risk assessments with the provider and the senior care staff and we all saw that several risk assessments were either missing or had not been updated in a timely manner. For example, one person needed to have the safety of their skin risk assessed and clear instructions put in place for staff to follow to keep the person safe. This risk assessment was not in place. Other risk assessments for issues around the safe use of oxygen machines, what food or fluid people needed to support their wellbeing and manual handling support were also not available. The provider told us these documents had not been completed. Risks to people were not consistently assessed and therefore people were not kept safe from the risk of harm.

People were not kept safe from risks associated with some aspects of the environment. Staff told us about and showed us two areas within the home which contained trip hazards. These were not marked or highlighted as a risk in any way. We also saw that when a drain cover had broken in the place where people stood to shower, the shower had continued to be used despite the danger of people injuring themselves.

After our inspection we became aware of concerns relating to the safety of a person who used the stairs at Meadow Lodge and who was considered unsafe to do so by a health professional. We asked the provider for information about how they kept the person safe and found that the risk assessments they had in place were not consistent and did not include a consideration of how accidents such as falls might be prevented for this person. Risks had not been appropriately assessed and action had not been taken by the provider to mitigate the potential harm to people.

People, relatives, and healthcare professionals we spoke with told us that they felt that the home should be cleaner. People's comments included; "I spend time in my room, I don't like the house it's dirty and smelly," and "The lounges are horrible, dirty really." Relatives told us, "Sometimes items of rubbish or urine are left unattended." A health care professional comment included; "The downstairs toilet is awful, it stinks and the sink and taps are filthy," and "I have an infection control issue there, there is nowhere to wash your hands, no paper towels or hand gel." They added, "There aren't any proper deep cleans, the carpets and curtains are dirty." We found that staff did not apply, and did not know how to apply, infection control practices at Meadow Lodge.

The provider did not follow national guidance in relation to infection control at Meadow Lodge, such as that produced by the Department for Health. Staff did not understand what they were responsible for when

monitoring infection control in the home. Staff told us they had received a online course and they did not feel knowledgeable about keeping people safe from infections. All the staff we spoke with said the home needed to be cleaner.

There were many areas of concern in relation to infection control that the inspection team saw at Meadow Lodge, these included bathrooms with no paper towels, no or broken soap dispensers, bins in bathrooms with no lids, and dirty flooring throughout the home. Tables, chairs, shower chairs, and wheelchairs showed evidence of not having been cleaned for many days. We saw that Meadow Lodge was unclean and in some cases unhygienic. For example, one person said, "I clean my own room every morning as I will clean it properly they don't, for instance do under the beds." A health care professional said, "The open bins in the toilets are dirty, they can be smelly, it's an infection control issue."

Staff told us that the washing machine had been broken for three days. A relative said, "There is no washing machine [my relative's] clothes are piled up in their room." The provider told us that the washing machine was being fixed on the day of our inspection but measures had not been put in place to remove the dirty laundry from people's rooms which would reduce the risk of infection within the home.

People were put at risk of increased infection as facilities and systems were not available for staff to maintain good hygiene. For example, people who used catheter bags experienced higher than average levels of infections (UTI's) and it was considered likely by health care professionals that these were exacerbated by facilities not being available to clean the equipment staff used. People were put at risk due to poor prevention and control of infection.

We saw that the provider had a comprehensive policy relating to infection control however it was clear that this was not adhered to. An internal audit had recently been completed in October 2017 this did not identify any concerns with infection control which is of concern given our inspection findings.
People received the majority of their medicines safely, but pain medication and the use of 'as required' medication was not safe or effective. Some people take medicine only when required (PRN), and we found that they did not have protocols in place to provide staff with enough information to know when and how the medicine was to be given. This meant people might not always be given their medicine consistently, and at the times when it was needed.

The provider did not use a system that supported staff to understand when someone who could not talk was in pain. For example, we found that one person who was not able to communicate verbally, had not received any painkilling medication for six days. There was no instructions or guidance for staff about this and staff could not consistently tell us how they knew if the person was in pain. We found that people who needed 'as required' medication could not be assured that they would get them as needed.

There was an inadequate infection control process, a continued unsafe risk management process and people did not always receive their medicines as required. This was a continued breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew what constituted abuse and what to do if they suspected someone was being abused. They knew how to report their concerns to the manager and/ or external agencies such as the Care Quality Commission or the Local Authority. Staff we spoke with could confidently describe the different signs and symptoms that a person might present which would indicate they were being abused and confirmed that they had received training in safeguarding to support their understanding. The manager had notified us about any concerns they had in relation to people's safety which included any incidents of potential abuse or serious injury to people.

People and relatives gave us mixed responses when we spoke with them about the numbers of staff that were available to meet their needs. One person said, "'I can't go out. There is not enough staff." Another person said, "There is enough staff around." A relative told us, "There is not enough staff and [my relative] has to wait." Staff told us that there were enough staff to meet people's care needs. Professionals we spoke with said that people's care needs were met but staff had to focus on getting care tasks completed rather than being able to spend time with people, and supporting them in ways that were not just direct care. One professional said, "The staff are so busy they can't care." During our inspection we saw that staff focussed on care tasks with people, but did not spend time with them. The provider did not have a tool to amend the staffing numbers depending on people's needs and we found that there were not enough staff to support people with anything other than care tasks.

The provider recruited staff safely. Recruitment processes were in place to help minimise the risks of employing unsuitable staff. We reviewed staff recruitment files and saw that the provider's recruitment process contained the relevant checks before staff worked with people. Staff told us that the provider had taken up references about them and they had been interviewed as part of the recruitment and selection process. The provider showed us the current DBS (police checks) that they held for all of the staff who worked at Meadow Lodge.

Medicine was stored safely in locked cabinets, and a separate medicines fridge was available if needed for medicines that needed to be kept cool. Controlled drugs are medicines that require special storage and recording to ensure they meet the required standards. We found that controlled drugs were stored securely and recorded correctly. Medicine that had a short expiry date once opened was dated to ensure that staff knew how long the medicine could be used for. Medicines were ordered and dispensed of appropriately.

Records showed people were given their medicines as prescribed, and the home used a pharmacy supplied system to make sure this was done safely. Medication Recording sheets (MAR) had been completed and staff could explain the process they had for checking the records were accurate. Care workers applied prescribed creams to people's skin. There was information available for staff on where and how often the creams should be applied. Staff administering medicines had received training and regular competency checks to ensure they remained safe to administer them.

We asked the provider about the systems and processes they had in place to learn from incidents and adverse events that might happen to people such as falls. After the inspection the provider sent us some information that indicated they had reviewed the risk of falls and had begun to analyse the causes. However, actions had not been put in place to reduce the likelihood of falls recurring. We also noted that one person who was deemed to be at risk of falls by a health care professional was not seen in the same light by the provider as they had not yet fallen whilst living at the home. We found that the provider was not proactive in learning from incidents or the input from other healthcare professionals in preventing possible accidents from happening.

Inadequate

Is the service effective?

Our findings

At our previous inspection of this service on 20 and 21 June 2017, we found the key area of 'Effective' to Require Improvement. There were two breaches of regulations in relation to the quality of the food provided and the application of the Mental Capacity Act 2005. At this inspection we found that some improvements had been made in relation to these areas and these regulations have now been met. However, we found that people did not receive effective care and therefore have rated this key question as inadequate.

During our last inspection we found that many people found that the food offered to them unacceptable. At that time people were experiencing significant weight loss and this had not been monitored by the provider. A person's weight can give a good overall indication about their general health. At this inspection we found that the provider had purchased a new set of weighing scales and people's weights were being monitored, and action taken appropriately.

We also saw that some improvements had been made in relation to the quality of the food, but some people still told us the quality of the food was poor. One person told us, "It's cheap rubbish food, terrible. It puts you off as soon as you look at it." Another person said, "It's lovely." A member of staff said, "I don't think it's the best food, it's the same thing; sausage for lunch, sausage for tea on one day. I would not eat it." Another member of staff said, "The food is basic, there's no variety, no quality." We looked at the menus and saw that there was a variety of foods, but people told us they did not enjoy it.

We had inconsistent accounts as to who was consulted in planning the menus. Following the inspection the provider sent us evidence that suggested people were involved, but people we spoke with told us they could not recall any involvement. Staff and people told us however, that if someone asked for a specific food, it was provided. We saw that the cook asked people during the morning what they would like for their lunch and gave them two options. This was done verbally without communication aids such as photographs to assist people in choosing. Some people would not be able to understand the verbal choice and they therefore were not given a meaningful choice of lunch.

We observed that people were only offered drinks at set times during the day. Staff confirmed that this was regular practice within the home. During the morning one of the inspection team was offered a hot drink while they were in the lounge area, but the people there were not. The inspector suggested that perhaps people might like a drink. We saw that when asked every person requested a hot drink. Staff told us people could ask for drinks if they wanted one, but we did not see this happen. People did not have sufficient access to drinks that met their preferences.

One person needed to have the amount of fluid and food they consumed measured to ensure that they remained well. We saw that the recording completed by the staff had gaps in it and fluids the person had consumed was rarely recorded and had not been totalled to ensure they were receiving the recommended amount. A senior member of staff told us they did not know this needed to be done. We found that records were not checked or reviewed by managers. One member of staff said, "[The person] does not have enough to drink." Not knowing the information about how much food or fluid the person consumed meant that the

provider could not be sure they were getting the nutrition and liquid they needed to stay well.

During the inspection we saw that some people did not eat all of their meals and staff came and removed their plate without asking if the person wanted an alternative, or if there was a problem with the food. A health care professional said, "There is no coaxing or encouraging with the food here." Another health care professional told us about a person who ate their meals in their room. They said, "[The person] is not supported to eat, they are left with their food in their room." We found that people were given food but not encouraged or supported to eat it in all cases.

People told us they did not have many choices of food. One person said, "I just have what is given to me." Another person said, "I would love to have a curry, when we do I will let you know." Staff we spoke with felt that there was not enough variety of food ordered which led to a lack of choice, for example they said that the dessert of fruit salad was only apples and oranges and other fruits were not ordered. Another staff member told us that people were only offered biscuits for supper. They said that had spoken to the provider about these concerns, but nothing had changed. One person told us, "It always sandwiches for tea." Staff also said that only one bunch of bananas was ordered for the home each week. In the dining room, we saw that one person had eaten a banana and reached for a second. Staff removed the fruit bowl from near the person, saying to another member of staff that the bowl should be moved or there would not be any fruit left. Other staff told us that when fresh vegetables were used up they needed to use frozen ones until the next shopping day. Meadow Lodge did not provide people with a good variety of food.

Staff told us that some people needed a soft diet or food that was safe for people with diabetes. We found that staff knew who needed which type of food and that people were supported to eat the correct type of food that met their health needs. Other people had preferences based on their cultural needs and preferences and these were also known by staff and respected. For example, one person said that they did not eat certain types of meat and they were never offered. We found that people were supported to eat the correct type of food.

People had their needs and choices assessed by staff at Meadow Lodge when they moved into the home. People and relatives told us they were involved in the initial assessment but not all people felt involved in their on- going care and support. We did not see that processes were in place to mitigate against any discrimination but we found that people who were from ethnic minority groups did not feel themselves to be discriminated against.

People were supported by staff who had received an induction when they started working at Meadow Lodge. Staff told us they felt ready to support people well when they began work. The provider had not yet introduced the Care Certificate, which is a nationally recognised induction programme for new staff. We found that staff had other types of training that meant that they exceeded this minimum standard when beginning work at Meadow Lodge. People told us that staff knew what they were doing and staff confirmed that they had on -going training that kept their knowledge up to date. However not all staff felt supported and the provider told us that supervisions of staff had not been consistently offered. We found that whilst training had taken place, there were significant gaps in staff knowledge about current good practice. For example, staff did not know the importance of measuring fluid intake, or the need to take preventative action to reduce accidents from happening such as falls.

Staff told us that they thought the team communicated well as a group and made sure that information relating to people was shared at handover meetings. People were visited at Meadow Lodge by their doctors and district nurses. People told us they saw their doctor when needed, and we saw that health care professionals were involved in supporting people with their medical needs. Health care professionals we

spoke with told us that, overall, staff carried out their medical instructions and that people received their medicines as prescribed. However when it came to preventing illness, health care professionals told us that staff did not always follow their advice. For example, some people used catheter bags which need to be emptied regularly to reduce the risk of urine infections. Health care professionals said that they frequently advised staff to empty the bags as people were having frequent infections. The health care professionals told us that this did not happen as advised.

People living at Meadow Lodge were not supported by an environment that was adapted to suit their needs. We saw that some redecoration had taken place since our last inspection that enabled people with dementia to begin to recognise bathrooms, as the doors had been painted blue and a sign had been attached to them. No other decorative improvements were noted, however we saw that some bedroom doors had numbers on and some had pictures of the people who occupied the room. Other ways of making the home more dementia friendly had not been considered.

We found that many areas of the home were dimly lit and in two places the floor had unmarked rises on it that might present a tripping hazard. Items had not been made available for people who lived with dementia to engage with such as rummage boxes. Some people who lived at Meadow Lodge had visual impairments and no adaptations had been considered to support them to move about independently. We saw that posters giving staff advice and guidance were on the dining room wall. This did not improve the sense of Meadow Lodge being people's own home. When people invited us into their bedrooms we saw a mixture of styles whereby some people had been supported to personalise their rooms and others had not.

There was a large garden area at the rear of Meadow Lodge that people could access. However, it was poorly maintained and the surface of the paved area was uneven. There were no handrails for people to use, and due to the nature of some people's conditions, not everyone would be safe to use the garden area. Risk assessments were not in place to support people to safely access the garden. People did not have access to a safe open space. We found that there was a designated smoking room for peoples' use. However the room was very dirty, the walls were very stained with smoke and the smell of smoking was extremely overpowering. The room was neglected and very poorly furnished. We did not see risk assessments for people relating to their choice to smoke. We found that if people chose to smoke the facilities made available for their use were not adequately maintained.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

When people lack mental capacity to make certain decisions, any decision taken on their behalf must be in their best interests and the least restrictive as possible. 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.

Two people living at Meadow Lodge had or were in the process of having a DoLS authorisation approved, and one person had an approved authorisation. The provider showed us the system they used to make sure that people who were subject to a DoLs authorisation had it reviewed as required. We saw that where necessary a capacity assessment had been undertaken by the provider.

Staff we spoke with did not know all of the people who were subject to a DoLS, although all staff knew that some people were. Staff understood that some people could not leave the home alone safely and they told us that when possible they would arrange for people to go out with staff. Staff knew that everyone should be given choices in their day to day lives, but one person told us that "We are told where we have to sit at the table." We found that staff understood they needed to offer people choices but people told us this did not consistently happen.

In some instances, when people became ill and did not want be resuscitated, documents known as DNACPRs are put in place by medical professionals. This document takes account of people's wishes and meant that people would not be given immediate lifesaving treatment. At our last inspection we found that the process for doing this had not been followed and that some people's wishes may not have been respected in these circumstances. During this inspection we looked at the records of four people and found that the records now reflected people's wishes and that staff were aware of those wishes and decisions. We also found however, that records relating to how those decisions had been made were insufficient and in one case incorrect. We found that the documents had not been reviewed with people and that one person had a form that had been produced by the hospital and not their GP. This meant that the person's wishes would not have been respected as the incorrect form was in place. After the inspection we spoke with the person's GP who said they would update the document as required. We found that people's wishes in relation to being resuscitated or not had been taken into consideration, but the process for doing so was not robust.

Inadequate

Is the service caring?

Our findings

At our previous inspection of this service on 20 and 21 June 2017, we found the key area of 'Caring' was Require Improvement. The concerns were around the lack of privacy and dignity for people. At this inspection we found that these areas had not improved. We found that the service was Inadequate in this key area.

People's privacy was not maintained. We looked at rooms that people shared. We saw that they had a privacy curtain in them but noted that these were short and did not protect the privacy of people when in bed or receiving personal care. We brought this to the attention of the provider who said they did not know this was of concern.

Some staff did not have an understanding of how to treat people with dignity at all times. For example, staff were seen to read and review records on the bed of a person when they were in the bed trying to rest. When challenged about this staff recognised that using a person's bed as their table when the person was in the bed was not appropriate. The inspection team also saw people with very full catheter bags walking around the home with the bags clearly visible at their ankles. People were not supported to maintain their dignity at all times.

People's independence was not actively promoted. People who lived at Meadow Lodge had a range of support needs and these were not met in ways that enabled people to maintain their independence. For example, one person had sight loss and other than a walking aid, there were no aids or adaptations within the home environment to support the person maintain their independence due to their sight loss while moving about the home.

People were not consistently supported to participate in planning or reviewing their care. Staff told us people were supported to express their views and wishes about their daily lives, but this was not always recorded in people's care records. People were not given information about their care plans or reviews of care in ways that were meaningful to them, for example, in easy read or pictorial formats. We saw some people participated in regular reviews of their care. However, for people who were less able to communicate verbally, there was no evidence of how staff sought their views, wishes and aspirations. It was not clear how relatives participated in reviewing people's care as this was not consistently documented. We found that the provider had not actively involved people in making decisions about their care as much as they could have been.

We did not consistently find that all the staff were kind and considerate. One person and one professional we spoke with said that some staff could be unkind. One person said, "The staff are caring and compassionate just the odd one who aren't. Sometimes staff can be abrupt." A health care professional told us they had witnessed a significant lack of kindness and compassion on a number of occasions. They reassured us that it was not a matter of unsafe care, more of an uncaring attitude from some staff. For one person we observed that they were in bed and were very cold. The person was not communicating verbally and felt very cold to the touch. We observed them pulling the blankets tightly to them as if cold. The covers

over them were small blankets and were not long enough to cover their shoulders and their feet at the same time. We asked why the person did not have more suitable covers given that they were clearly cold. The provider confirmed that more covers were available. When we returned the following day we saw that the person had the same insufficient blankets on them. Following our inspection we raised a safeguarding alert with the local authority in relation to this and associated matters. We found the provider did not have effective systems in place that supported staff to understand the required standard of care they should be giving.

During our inspection we saw some examples of people being treated with kindness and we saw examples of staff giving support in a caring manner when they had the time to do so. One person told us, "They do the best they can." Another person told us, "The majority of the staff are helpful." We saw that staff completed tasks with people kindly but did not have time to spend with people and engage with them in meaningful conversations.

Inadequate

Is the service responsive?

Our findings

At our previous inspection of this service on 20 and 21 June 2017we found the key area of 'Responsive' was Require Improvement. The concerns were identified as a breach of Regulation 16 and were in relation to an ineffective complaints procedure. At this inspection we found that sufficient and timely improvements had not been made and the service remains in breach of Regulation 16. We also found that the service was in breach of Regulation 9 due to an inadequate person centred approach. We found that the service was now Inadequate in this key area.

People received care and support that was not always planned in a way that met their individual needs. Meadow Lodge has bedrooms that are shared by up to two people. We found that there was no method or process used to make sure that people who moved into shared rooms wanted to do so. There was also a lack of understanding within the staff team and the provider about the need to ensure meaningful consent was gained from people who this affected. For example, one person had lived in their room for some years and was now extremely ill and remained in bed. Another person had been accepted at Meadow Lodge as an emergency placement. This meant they moved in very quickly, and they were placed in the room with the ill person. Meaningful consent could not be gained from the ill person, and their needs and preferences had not been taken into consideration. When we spoke to the provider in relation to this they were aware this had happened. A staff member informed us that a single room had become available for the emergency respite person over seven days before our inspection. The provider told us they had not considered anyone moving into the single room as other people would be moving into the home shortly. We found that people did not always receive care and support that reflected their needs and preferences.

People were not supported to bathe or shower when they wanted to. People told us that the personal care that staff gave was task focussed and did not consider people's holistic care needs and preferences. Staff and people told us that the home operated a system of offering showers or baths to people on set days. Staff said this was linked to when people's bed clothes were changed, and that people were only offered a shower or bath twice a week. Staff said that if a bath or shower was required for a specific reason between the set times, it would be offered. One person we spoke with told us, "I like to shower every other day, but there's no time, and the staff say I have to be on their list. I have to wait." We observed that some people had not been supported to shave well and many people looked unkempt. People's care was not person centred and did not reflect their preferences or meet their needs.

People were not supported to follow their interests or participate in meaningful activities. The provider told us that the total staff care hours at Meadow Lodge had been reduced by seven hours a week so that those hours could be used to provide activities for people. We looked at a recent activities audit that appeared to show that people had many opportunities for meaningful interaction. However no one we spoke with confirmed this. All the people we spoke with said not enough happened within the home, comments included, "There is not enough to do just sitting around," "I don't do anything all day," and "I did like going out for a stroll. I've asked about 3 times to go out." Several people told us that in the past they had various hobbies and interests and that they did not have access to these now, one person said, "I do get bored. I get up at 10am it would be good to do more…I wish I could meet other people or go to a support group." During

our inspection we observed people sitting in communal rooms for long periods of time with no interactions or activities.

Community relationships had not been maintained or developed. Staff could not tell us of any connections within the community and Meadow Lodge, such as links to a church group or schools . During our inspection we did not see any meaningful activities taking place and people did not have access within the communal rooms to items such as magazines, newspapers or other items of interest. The service did not encourage people to take part in social activities or follow their interests.

The service had not implemented accessible information to an acceptable standard. While we noted some minor improvements had been made with regards to signage within the home this did not meet all people's needs. For example, one person with sight loss did not have any information within the home that was accessible and appropriate for them. We found that people at the end of their life did not have their needs reassessed as their needs changed. We saw that one person had an end of life care plan in place that did not reflect their current needs, and staff therefore did not have clear instruction and guidance about how to support the person safely and well.

We found that equipment was not always provided in good time. For example, a specialist bed had been ordered by district nurses for one person's comfort and wellbeing and this had not been accepted into the home when it arrived. The provider and staff did not have an understanding of the importance of the equipment and made no attempt to rectify this situation until it was brought to the attention of the provider at the inspection. We found that staff had not received effective training in relation to end of life care. A health professional told us that they had no confidence in the knowledge of the provider or the manager in relation to supporting older people with significant health needs. We found that national guidance in relation to end of life care had not been considered at Meadow Lodge. We saw that staff attempted to support and care for the person to the best of their abilities but they in turn were not supported by guidance from the provider or knowledge and skills from training about how to do so well.

The lack of person centred care and support for people is a breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's complaints were not responded to and there was no apparent learning from them within the service. We saw there was a formal complaints process in place and where complaints had been raised formally they had been responded to, but there was no analysis in place or evidence to suggest lessons were learnt to prevent a reoccurrence. For example, when a relative had complained about an offensive smell at Meadow Lodge, their formal complaint had been responded to appropriately, however offensive odours remained in other places in the home.

We saw a new leaflet had been produced to support people to make complaints, but this had not been effective. We saw a complaints and compliments book in the home reception area. There had been three entries made in it but we did not find any evidence that the issues had been addressed by the home to the satisfaction of the complainants. In one instance a person had clearly written about what concerned them and the problem still persisted. The complaint had not been addressed to the person's satisfaction. The provider said they had spoken with the person about the issues they raised but they remained unsatisfied. The provider's complaints process remained ineffective in supporting people to complain and be listened to.

We found that one person had repeatedly complained about their bed being too short. They said, "I get a stiff neck all the time." The person explained that staff tried to help by using a rolled up duvet to extend the

bed but this was ineffective and fell out. The person's complaints had not been listened to for over a year. When we raised this with the provider they said that they did not know where to buy a longer mattress from. We found that concerns and complaints raised by people were not dealt with in a timely and appropriate way, and this negatively impacted on some people's wellbeing.

We found that sufficient and timely improvements had not been made in relation to the complaints processes. This was a continued breach of Regulation 16, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection of this service on 20 and 21 June 2017, we found the key area of 'Well Led' to be Inadequate. The concerns were identified as a breach of Regulation 17 and were in relation to an ineffective auditing and monitoring process to mitigate risks, improve quality or to adequately maintain contemporaneous and accurate records. We served a Warning Notice and the provider sent us an action plan in response to the concerns identified. However, at this inspection we found that the actions had not been completed. We found that sufficient and timely improvements had not been made and the service remains in breach of Regulation 17. We found that the service remained Inadequate in this key area.

There were systematic and widespread failings in the oversight and monitoring of the service which meant people did not always receive safe care which maintained and improved their well-being. Despite previous inspections identifying shortfalls in governance systems and the quality of care provided, we found that insufficient progress had been made to the auditing and governance systems of Meadow Lodge. For example, the systems to monitor risks remained ineffective because action had not been taken to address these issues. We saw that the provider had lists of audits but no actions had been taken in light of these lists. People's risks were still not assessed and updated as necessary which meant people were placed at risk of unsafe or inappropriate care. The oversight and monitoring of the service was ineffective and the provider's systems had failed to ensure that previously breached regulations had been met.

The monitoring and oversight of the service also remained ineffective in relation to the quality of service people received. For example, people still lived in an environment that was not clean and in some cases presented an infection risk. People did not have access to meaningful activities that they enjoyed and the care provided remained task focussed and not person centred. We also found that there was no focus on the experiences of the care people received, or their opinion of that care. The provider did not understand the principles of good quality assurance and there had been very little improvement in this area since our last inspection. We did not find evidence of where learning had taken place in light of adverse incidents to reduce the likelihood of them happening again.

People were not included in the care they received or the running of the home. Whilst we saw that staff asked people about small day to day decisions within the home, there was no method of including people in bigger decisions about their care, support and service they received. At the time of our inspection, surveys or other methods of collating opinions or views about the service provided had not been undertaken with people or their relatives. This meant that opportunities had not been taken to gather feedback to improve the service for the people living at Meadow Lodge.

The provider did not have systems or methods in place to continuously learn, and therefore improve the service. For example, while we noted that there were some improvements in the complaints procedure itself, it had not been implemented in such a way as to improve service or to learn from concerns or errors. People's voices were not heard when they expressed concerns. The provider had some contacts with external organisations but it was not clear if any learning from external agencies was implemented. The provider could not give us examples of how improvements had been made in light of current guidance or

learning from other agencies.

The assessment and monitoring of the service to mitigate risk and drive improvement was not effective. This was a continued breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was not in post. During our inspection we did not meet the acting manager who had recently been appointed to post but staff told us that they had a clear vision about how to improve the delivery of services to people who lived at Meadow Lodge. One member of staff told us, "The morale of the staff is better now that [the new manager] has taken over." However another member of staff said, "The new manager doesn't listen to staff, just walks off." We found that while some areas of leadership had started to improve, the positive impact for people had not yet been felt by them. For example, people were still not receiving care that was person centred or safe.

The provider had ensured that regulations relating to notifications had been met and the manager was sending notifications to us as required. We also saw that the ratings of our previous inspections were displayed in the premises appropriately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care that was appropriate to their needs and met their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care and treatment of people was not safe and the provider sis not consistently assess the risks to people or do all that was reasonably practicable to mitigate them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not consistently investigated or acted upon by the provider in an effective manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processed are not operated effectively to improve the quality of the service or to mitigate risks.