Mr H G & Mrs A De Rooij

Melrose

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We carried out an unannounced, comprehensive inspection of this service on 13 January 2015. Breaches of legal requirements were found. After the inspection the provider wrote to us to say what they would do to meet legal requirements in relation to consent to care and treatment, meeting nutritional needs and submitting statutory notifications.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Melrose on our website at www.cqc.org.uk

This report covers our findings in relation to those requirements. In addition, during the inspection on 07 and 10 September 2015, we found that there were concerns relating to medication and staffing which we have included in this report.

The home required a registered manager. A registered manager is a person who is 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. Melrose had a registered manager who had been in post for several years.

At the last inspection on 13 January 2015, we asked the provider to take action to make improvements relating to

Summary of findings

consent, nutrition and hydration, and statutory notification submissions. The provider had provided us with an action plan which stated that they would achieve these requirements by 31 May 2015. We found that they had met the requirement regarding nutrition and hydration but had not met the requirements relating to consent and statutory notification submissions to the Care Quality Commission (CQC). The provider had not improved the training and understanding of the Mental Capacity Act and had not completed the necessary capacity assessments. The provider had not submitted the required statutory notifications to CQC as required as we knew there had been concerns raised by other organisations to CQC.

During the course of this inspection we found that there had been a serious medication error which had gone unnoticed. We had also been notified by whistle-blowers that there were not enough staff throughout the course of each day and night. The provider had sent us a copy of the staff rota which showed that there should be at least five staff members on duty throughout the day. However we found that this was not people's experience. We also found on the days of our inspection that there were insufficient staff on duty.

We have made a recommendation in relation to the staffing levels.

We found breaches of the Health and Social Care Act 2008, relating to consent, statutory notifications and medication administration. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

We found a medication error which had not been noticed or addressed.

People complained that there was not enough staff to support them.

Requires Improvement

Is the service effective?
The service was not always effective.

We found that staff had not had training for the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards.

People's mental capacity had not been assessed and their independence was not encouraged or enabled.

People had better access to food and drink and most were able to access these independently.

Requires Improvement

Is the service well-led?
The service was not well led.

The provider had not notified CQC of serious concerns and incidents since our last inspection, despite assuring us they would do so.

Requires Improvement

Melrose

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

The inspection took place on 07 and 10 September 2015 and was unannounced. The inspection team consisted of two Adult Social Care inspectors and two specialist advisors. One of these special advisors was a social worker who had particular expertise in mental health and the associated legislation and the other specialist advisor was a mental health nurse.

We considered the information that we had on our systems and contacted the local authority to see if they had information to share with us.

We looked at six care plans, eight medication records, and other records relating to the service. We talked with 10 people who lived in the home and one relative who was visiting at the time of our inspection visit and two professionals involved in people's care, during the days of the inspection. We also spoke with the registered manager, who was also one of two people in the provider partnership, the other partner and with four staff. We also viewed the training records for 11 staff.

We asked for contact details of staff and relatives and professionals involved in supporting people who lived in the home to be sent to us after our inspection which was later received. After our inspection visit, we telephoned and spoke with a further three relatives and two professionals.

Is the service safe?

Our findings

In the course of our inspection we looked at the medication processes, initially to see whether people's consent was obtained.

Although one of the professionals we spoke with told us, that, in their opinion, "The medication records were in order", we found that there were areas of concern around medication.

We found there was a clear medication policy in place which indicated that staff were given medication training prior to administering the medication and that only staff who had received this training could administer medication.

We saw that the medication administration records (MAR) contained a recent photograph of person they related to with known allergies and date of birth, so that each person could be easily identified and ensure that the right medication was given to the right person. We noted that there was information about the local pharmacy which dispensed the medication and who also audited prescriptions for any contra-indications.

However on stock checking the controlled medication we saw that controlled drugs were not always stored in the controlled drugs cabinet. There were two different controlled drugs found in drawers in the medication room which should have been stored in the controlled drug cupboard.

There was a small medication fridge in the medication room which we noted was leaking water. This put the stored medication; insulin, at risk of being ineffective. This was because the temperature could fluctuate and could compromise the efficacy of the medication and therefore was a risk to the people requiring the medicine.

When we checked the controlled drugs record register against the stocks held in the medication room, we found that the medicine, 'lorazepam' had been recorded in the register as being 56 in stock, but we found only 27 tablets. We discussed this with the registered manager who told us that the drugs were audited daily and weekly by staff. We spoke to the staff member who had signed the controlled drugs register as having 56 tablets and they could not account for the error, nor could they tell us why this had not been spotted in the frequent audits.

We alerted staff and the registered manager to this error. During the course of the inspection the matter was investigated by staff who were not able to locate or account for the missing drugs. We found that nobody had been harmed through this error. However, we later reported this matter to the relevant authorities and advised the provider to report it as a possible crime, to the police. The provider told us that they had reported the matter.

This is a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the registered manager was present and there was a cook, an administrator, and two other staff members. One of these was an agency staff member.

One person told us, "Staff are scarce". Another told us that due to staff shortages sometimes the toilets weren't cleaned and they said this was, "Annoying". Another person told us that due to staff shortages, other people who lived in the home helped them into the dining room and that if he needed help it could take a while for staff to come due to low numbers. The administrator was often supporting people in their requests for money, cigarettes and advice and information. We had seen that staff were very rushed during the medication rounds.

People told us that there was, 'nothing to do' and that staffing levels were low. Although the people living in the home were physically, fairly independent, their mental health needs were not always met. We saw that this was because staff levels were low and there was little therapeutic activity for people in relation to their mental health issues.

People told us that they didn't understand that they had a care plan or a key worker. A key worker is a staff member who takes special interest in the needs of the person they are supporting. People told us that they found it difficult to 'find' staff and staff were, 'always changing'.

The registered manager told us that they had been trying to recruit staff for the last few months. They also told us that they had been dissatisfied with the previous recruitment agency due to them sending staff who did not speak English very well. They had recently employed several members of staff in the last few weeks.

Is the service safe?

We recommend that due regard is paid to the need for appropriate levels and skill of staff to meet all the needs, both physical and therapeutic, of the people being supported in the home.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

"You'd expect more DoLS applications in a place like this", a professional told us.

At our last inspection we found that the provider did not obtain consent from people in relation to their care and treatment. The MCA and DoLS requires providers to submit applications to a 'supervisory body' for a DoLS authorisation, where people lack capacity. We found that there was no evidence of MCA or DoLS being applied in practice and there was no record of any capacity assessments, best interests meetings or decision-making in people's care files. Although we were told at the last inspection that DoLS applications had been made we did not see any record of this on this inspection.

After our last inspection the provider produced an action plan which told us that care plans would be reviewed, consent forms obtained from the people relating to care and treatment and that they would assess capacity of any people that required it. This would be achieved by 31 May 2015. This action plan also stated that there would be on-going staff training and audits completed by the management in relation to this and other areas. We saw that there were some consent forms relating to mainly money and cigarette consumption.

When we looked at the training records for staff in relation to Mental Capacity Act 2005 (MCA) and the associated DoLS we found that staff had not had training since our last inspection. There were many new staff employed (half of the staff establishment) since the last inspection and this meant that they did not have an understanding of the legislation. We asked staff about this legislation and they were not able to tell us what it was. We were told by a staff member that they had not received any training in relation to this and they said, "Not so far".

The care records that we saw showed that there were no mental capacity assessments done for people living in the home and there was no record of any 'best interest' meetings or DoLS applications. From the documentation and observations we saw it was apparent that there were aspects of people's lives which indicated that they may not have capacity. The registered manager told us that they had not made any applications. We had conflicting statements from the registered manager, such as, "All residents are assumed to have capacity" and then, "I think we have people here who lack capacity".

One professional told us, "[Name] loses capacity when they are unwell".

People making mental capacity assessments should generally be carried out by the person(s) providing care or treatment, such as a staff member supporting someone who doesn't want to have a bath. We asked the registered manager if they had made any capacity assessments for the people living in the home. They told us they hadn't. They told us that they expected other professionals involved in people's care to make such assessments. We did not see any record that other professionals have been requested to make such assessments.

When we asked the registered manager whether they knew about the Cheshire West judgement, they told us that they did not know about it. They asked us how they should be expected to know about it. The 'Cheshire West' judgement related to MCA and DoLS and part of it was about adults in care home settings. It asked, 'Is the person subject to continuous supervision and control and is the person free to leave?' (temporarily or permanently). It is a provider's responsibility to continuously update themselves about current practice and legislation. This judgement was very well publicised and discussed in all the professional journals and on national media and the information was, and is, currently available on the CQC website as well as other organisations' healthcare internet sites.

People living in the home had various mental health illnesses including some cognitive impairment. Some people also had a physical disability. People were able to access the community, but were not able to get back into the home without ringing the bell. When we asked why people were not able to have a key, we were told this was for security reasons and that people would lose them.

Requires Improvement

Is the service effective?

People had to wait, sometimes for long periods, for a member of staff to answer the door. This meant that people could not access their own home independently and that staff controlled that access.

We saw that people would come to the office to ask for money or cigarettes. The money and the cigarettes were kept in a box in a locked drawer. There were individual wallets in the box, which contained people's money, lighters and cigarettes. We asked why this happened and we told that the people had wanted this to happen because they realised that they would overspend or smoke too many cigarettes. However, we saw in the records that there were notes saying that staff and management had decided, for example, how many cigarettes a person would be able to have and over what intervals during the day.

We were told that there was agreement between people and the provider and we were shown signed documents to say that this had been agreed. We were doubtful that some people had the capacity to understand this arrangement and to knowingly consent. One person did come to us to tell us that they had no problem with this arrangement. However, we witnessed that some people came to the office and asked for their money and cigarettes in a pleading way. We also noted that records were kept about how many cigarettes had been given out and how much money had been given out.

We did not see any evidence that a rigorous consultation and decision-making process had been carried out about money and cigarette management. Although we were told that one person had consented to money management, the professional involved in their care told us, "They do restrict everyone with their money. I do find that strange".

We observed that people were not aware of why they were taking their medication because we did not hear any explanation that was given to people when they were given their medication. We did not see or hear that consent was obtained. We saw a medication round which was rushed and hurried due to low staffing levels and we saw that people were not given time to ask any questions about their medication. One person told us that they were unclear about why they were on a certain medication and what it was used for. There were no capacity assessments in place in the care records for people who refused to take their medication.

The information provided by the provider to us included information about a person who was neglecting their personal care. This person had not had a mental capacity assessment whilst they were living at Melrose in relation to this issue.

These examples are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the need for consent.

During our last inspection we found that people had experienced restricted access to food and drink. On this inspection we found that the situation had improved. People had their own trays, kettles, drink supplies and biscuits in their own rooms and could also access kitchen facilities to make things such as toast.

One person said about the food, "It's as good as it could be". Another person told us that, "There's nothing wrong with it". We also had comments that the 'portions were too small', and that one person had found the choices, 'boring'.

We saw that one person requested an alternative to the meal on the menu that day, which was prepared for them. The cook on duty told us that there were monthly catering meetings with people to discuss menus. This was confirmed by one of the people we spoke with. Overall, we found that the situation had improved and most people were happy with the new arrangements

Requires Improvement

Is the service well-led?

Our findings

One person said, "Melrose is not a bad home, I've been in some others and it is better than some. Staff are pretty friendly including the manager and his wife; he's a nice bloke." This person found the registered manager approachable and, "Not like some".

We received information from whistle blowers that the manager was unapproachable. We found that people living in Melrose were not confident in approaching the manager. They told us that this was because they were not treated like an individual and that their views didn't matter to the service.

We had received information of concern from several sources, such as whistle blowers and the local authorities safeguarding team. Two of these were about the attitude of the management towards the staff and also about the manager's approach to people living in the home. We had also been notified of several incidents such as one person not having a suitable bed for their condition, another being denied a meal and one person not receiving suitable medical treatment after a fall where they had sustained a serious injury.

We discussed the lack of notifications with the provider and other staff. The registered manager and the staff provided us with three 'complaint investigation' forms which showed us that there had been investigations into these complaints. These 'complaints' were incidents of the type which should have been reported to us as required by law as soon as possible after the event. However, they had not submitted statutory notifications to inform CQC relating to these.

The provider submitted, after the inspection, seven retrospective statutory notifications, three of which related to the complaint investigations that they had undertaken and had provided us with copies of the records. These statutory notifications referred to incidents which happened in December 2014, March 2015, April 2015 and August 2015. We still have not received a statutory notification about another serious incident reported to us by the local authority on 29 June 2015. This incident had been investigated by the home and was one of the three investigation forms we saw.

The provider had assured us in the action plan from the last inspection in January 2015 that they would provide retrospective statutory notifications relating to the previous inspection, by 31 May 2015. As the statutory notifications retrospectively submitted after our inspection in September 2015 included three from December 2014 and two in the March and April 2015 they clearly had not met the action plan. Furthermore, a further four statutory notifications had not been submitted between the action plan date and the September 2015 inspection, as well as the missing one from the information we had from the local authority.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 regarding the notification of other incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured the proper and safe management of medicines.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who used the service were not assessed properly in relation to the Mental Capacity Act 2005 and the associated Deprivation of Liberties safeguards. Regulation 11.

The enforcement action we took:
We have issued a Warning Notice which must be complied with by 31 January 2016.