Edgbaston Healthcare Limited

Melville House

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

Summary of findings

Overall summary

This comprehensive unannounced inspection took place on 9 and 10 October 2018. The inspection team consisted of two inspectors, a specialist advisor who was a Registered Nurse 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 service.

At our last inspection in March 2018, we found the provider to require improvement in all five key areas. We also found breaches in Regulations 12 and 17. Regulation 17 was breached with a Notice of Decision being served upon the provider to return monthly reports to us to demonstrate continued improvement. The reports have been returned to us as specified. However, at this inspection we did not find the required improvements had taken place and the breaches were not met.

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

Melville House accommodates up to 29 people in one building. The building was not purpose built and is formed of two large houses being joined together with corridors. The home does not have 29 individual rooms and up to 8 people use shared bedrooms.

At the time of our inspection Melville House did not have a registered manager in place. A new manager had begun working at the home and had applied to become registered with us. 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.

Melville House did not keep people safe. Not all people had up to date or accurate risk assessments. People were not always protected from the risk of cross infections and the environment of the home was not clean. Lessons were not learnt from accidents and incidents that had happened. Staff understood how to safeguard people and medicines were given safely.

People were not always supported effectively. People were not involved in the planning or review of their care and staff did not always demonstrate that they had the skills to deliver effective care. The design of the premises was not effective in delivering the best possible care and there was no signage for people to orientate themselves. People did not always consent to the care and treatment they received. People had enough to eat and drink and were supported to live healthier lives with good involvement of health professionals.

People said that staff were caring and kind, but we saw that people were not always treated with dignity. There was no approach at Melville House to promote people's independence. People received their care in

private, but were not actively involved in making decisions about their care.

Melville House did not always respond well to people's needs. People were not involved in their care and may not have had their decisions about when to be resuscitated known about by staff and managers. People were not supported to maintain their interests or hobbies and had very few activities to take part in during the day. Melville House did not comply with the Accessible information standard which meant that people did not have information in a way that they could access easily.

Melville House was not well led. The provider had not improved the effectiveness of the auditing system as required by law. The provider had also failed to ensure that notifications were returned to us as required by law. The vision to make improvements and to meet standards was not clear.

We have made a recommendation improving the environment for people living with dementia.

At the last inspection on 22 and 28 March 2018, we asked the provider to take action to make improvements in relation to safety, notifying us of events and the quality assurance processes. At this inspection we found that insufficient progress had been made in these areas. The provider remains in breach of these areas. 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?

Requires Improvement

The service was not consistently safe.

People did not have accurate or up to date risk assessments.
People were not always protected from infections.
Lessons were not learnt from accidents and incidents.
People were supported by enough staff.
Staff understood how to report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not involved in the assessment or review of their care.
Staff did not always have the skills to support people well, such as knowing when people could choose to leave the building.
The design and adaptation of the building was poor.
People had food and drink and access to health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

The service was not promoting peoples' independence.
Peoples' dignity was not always being upheld.
People were not involved in decisions about their care.
Peoples' privacy was protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not contribute to their care planning or reviews.
People were not supported to follow their interests.
Complaints were responded to in a timely manner.

Is the service well-led?

Inadequate

The service was not well led.

There was no clear vision, or robust plan about how to make sustained improvements.

The quality assurance processes were not effective. Notifications had not been returned to us as required by law.	

Melville House

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.

This comprehensive inspection took place on 9 and 10 October and was unannounced. The inspection team consisted of two inspectors and a specialist advisor with detailed knowledge of nursing care. The team also included 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, in this case 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. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also examined the information we hold in relation to the provider and the service. We used this information to plan what areas we were going to focus on during our inspection visit.

During our inspection, we met and spoke with seven people who lived at the home and six relatives. We spoke with one visiting care professional to get their views. In addition, we spoke at length with the manager, seven care staff and the cook.

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 to us. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time. At the time of the inspection, the local authority and the CCG (Health Authority) had decided to restrict further admissions of people going to live at Melville House, until they are satisfied improvements have been made.

After the inspection, the provider sent us the information we had requested during the inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2018, we rated this key question as Requires Improvement. This was because the provider did not make sure people's risk assessments were always current or accurate. We found there was a breach of regulation 12, safe care and treatment. At this inspection, we found sufficient improvements had not been made and the rating for this key question is now Inadequate.

The service placed people at risk of harm as risks to people were still not being assessed sufficiently and all practicable measures had not been put in place to keep people safe. For example, one person had behaviours that might be considered as challenging. We found they did not have an accurate risk assessment in place that told staff how to support the person when they became distressed. Staff we spoke with used various methods to support the person but these were not consistent. Not all staff had received training in how to support people with behaviours that challenge and we saw that their skills and knowledge in doing this varied. The person had also experienced a significant change in their behaviour over some months which had not been identified by the provider and as such no actions had been taken to ensure their safety such as contacting external experts to seek advice.

We found that where action had been taken to address risks that plans in place were not followed and contradictory. For example, we found that risk assessments to reduce people's risks were not routinely followed We saw that some people needed to have special air flow mattresses to keep their skin safe from damage and these mattresses are set to match the weight of the person. We saw that the settings on two of the mattresses were wrong and this meant that people may experience sore or damaged skin as a result. We also saw that bed rail risk assessments were contradictory and risks relating to the type of diabetes one person had was unclear. People were not kept as safe as reasonably practicable.

People were not kept safe from the potential risk of harm from food. Staff did not follow safe food hygiene practices well. For example, we saw a staff member pick food up off the floor and put it back on a person's plate. When the staff member saw they were being watched the food was removed. We noted on two separate occasions that food had been left out in a lounge area that would spoil if not kept cold. It had been left out overnight and could have been eaten by people which would have made them unwell. We found that some prescribed supplementary food was in a lounge area and could have been eaten by people it was not prescribed to.

We noted that the home had recently had a Food Hygiene inspection, and was awarded 3 stars out of a maximum of 5. There was an action plan in place to make improvements. We saw that not all the points on the action plan to improve this rating had been completed by the provider meaning that people were still at risk of unsafe practices around food hygiene.

The environment of Melville House was not always safe. We saw that a maintenance book was completed but that the jobs in it were not done in a timely manner. For example, we saw an entry about a broken mirror in a person's bedroom from four months before the date of the inspection had still not been replaced which presented a risk to people. We found other instances of the maintenance of the building not being kept up

to date or safe. The provider and manager were unaware of the current maintenance issues we identified through the inspection. At the end of the inspection the manager told us these concerns would be addressed.

People were not kept safe as equipment they were using had not been serviced in line with expected standards. We saw that hoists that were being used were due to be serviced in June 2018. The manager showed us an email that confirmed that servicing would take place four months after that date. The servicing of wheelchairs was due January 2018 and had not been completed or had a planned completion date at the time of the inspection. The lack of timely servicing of equipment placed people and staff at risk of injury.

This is a continued breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe Care and Treatment.

Some people had expressed their wishes about if to resuscitate them or not in the event of a medical emergency. Their wishes had been recorded on a form known as a DNACPR. DNACPRs are orders that are authorised by medical professionals that respect the wishes and ensure the best interests of people who may or may not want to be resuscitated under certain medical circumstances. It is the responsibility of the provider to know who has these orders and to make sure they are readily accessible in an emergency. We saw some of these DNACPRs were on peoples' files but were told by the manager that there was no central list or record. Staff we spoke with could not consistently tell us who should or should not be resuscitated in the event of a medical emergency. There was no system in place to make sure the information was available.

The environment of the home was not always clean or well maintained. We noted that floors and tables were visibly dirty and sticky and furniture in bedrooms was scuffed and stained. We saw two areas of mould on the walls where wall paper had peeled away. At this inspection we found that the provider had still not considered the impact of the environment on people with dementia and any potential risks or confusion this may have caused.

We recommend that the provider refers to current guidance or seeks advice from a reputable source on best practice for the environment of people who live with dementia.

Staff told us that they had enough equipment to protect people from the spread of infections such as aprons and gloves and we saw that these were used.

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 registered 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 a good understanding of their responsibilities in maintaining the safety of people from this type of harm.

People and relatives felt there were sufficient numbers of staff to respond to their or their family member's care and support needs. We saw that there were enough staff available to meet people's needs and complete tasks for them without them waiting. People told us there were enough staff for them and relatives also commented that staff numbers were sufficient. One relative said, "I think there are enough staff here." One member of staff said, "Yes we have enough staff on duty." We reviewed staff files and found the provider had completed pre-employment checks to ensure staff were suitable to work with people. These

recruitment checks included requesting references from previous employers, identity checks and Disclosure and Barring Service (DBS) checks. DBS checks help providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people. In one instance however, the provider had not ensured they had followed a safe procedure when a member of staff had some concerns with their recruitment checks. We brought this to the attention of the manager who assured us it would be resolved as soon as possible.

People received their medicines on time and as prescribed by their GP. People told us they were happy with the way they were supported with their medicines, one person said, "I do get my medicines, the staff give them to me." A relative told us, "They manage the medicines correctly." Care plans provided staff with guidance to ensure people took their medicines safely and as prescribed.

There were systems in place to ensure people received their medicines as prescribed which included monthly audits carried out by the manager. We saw the staff member informing people about their medicines and asking if they required any pain killing medication. Medicines were administered in a safe and unrushed manner. We observed the member of staff obtaining consent from people before giving them their prescribed medicines. We looked at the medicine administration record (MAR) and the controlled drugs book for some people who lived at the home. We checked the balances for some people's medicines and they were accurate with the record of what medicines had been administered. We noted however that not all the medicines had been signed for and dated, and that the recording of where skin creams and medicinal skin patches had been applied was not clear. The manager told us that this issue would be addressed immediately. We saw that staff who were responsible for administering medicines had received regular training.

We saw that plans were in place to manage emergency situations. In the event of a fire emergency evacuation plans were in place for each person which detailed whether people needed equipment to mobilise.

The manager recorded incidents and accidents that happened within the home. However, there was no analysis or consideration of these events to try to identify any areas for improvement and to look for any trends. For example, one person had several falls that had occurred in one month and this was not looked at overall to see if anything could be done to reduce the likelihood of repeat occurrences.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2018 we rated the registered provider as 'Requires Improvement' in this key question. We found that people were not supported by staff that had the skills and knowledge to support them effectively. People were not supported in a way that protected them from unlawful restrictions or had meaningful consent gained from them in all cases. We also found that the environment was poor and that there was no appropriate signage for people living with dementia. We did not find improvements had been made and at this inspection the rating remained as Requires Improvement.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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 had the appropriate legal authority and were being met.

At the last inspection we found that the provider had submitted applications under DoLS as required, but that staff did not consistently understand what that meant. At this inspection we found this had not changed. Staff were still not sure who was subject to a DoLS and who was not. This meant that staff did not know who could leave the building on their own and who could not. One member of staff said," People can't really leave I don't think, I'm not sure who has capacity." Another member of staff told us they did not understand what DoLS was.

We asked the manager to tell us which people had Lasting Powers of Attorney. These are legal powers that some relatives and others can have authorised by the court of protection. It is the responsibility of the provider to know which people living at Melville House have these orders. When we spoke with the manager they explained that they did not currently know which people had Lasting Powers of Attorney. The provider had not ensured that people's rights were protected.

People had not given meaningful consent to sharing rooms. We saw that one person who was very frail and anxious was sharing a room with a person who had significant mental health concerns. A member of staff said, "[Person 1] can shout and get really upset and [person 2] just has to put up with it." We spoke at length to the manager about how people consented to share a room. The manager was unable to assure us that people gave meaningful consent to sharing a room and had not completed any best interests interest meetings or recorded any discussions about this issue with people or their relatives. Following this

inspection, the manager sent us a new policy that detailed how consent would be sought from people in the future.

At our last inspection we identified that the premises were not designed to support people living with dementia well. At this inspection we saw that the premises had still not been adapted and decorated to support people to move easily from their own bedroom and around the communal areas of the home. The physical environment was not decorated or adapted to meet individual needs such as signage for people living with dementia, reminiscence areas or objects of interest. There were no private spaces for people to meet visitors in, other than their bedrooms. This was not a suitable arrangement for those people sharing a bedroom.

People were supported by staff who had received some training and supervision. Supervision had not happened until the new manager came into post in May 2018, and was therefore an improvement. Staff training was not comprehensive and we found that less than half of the staff had received training in relation to dementia or challenging behaviour. One member of staff said, "We haven't had any training about mental health things and [one person] has psychotic issues, but I just treat [the person] the same as anyone else." We asked the manager if there were any processes to check staff practice and it was explained that while spot checks of staff do take place, they are random and not recorded. A senior member of staff told us, "Staff are not the best they could be, there is lots of poor practice, they don't really know what they are doing." Staff we spoke with told us that they had received an induction when they started work.

Staff did not consistently work well together and people could not be sure they would be well supported when moving between services. We saw that staff participated and contributed to handovers between shifts to enable staff to facilitate continuity and provide good outcomes for people. However, not all staff thought that the staff team worked together well. One member of staff said, "I don't think the staff are working together really well." Other staff we spoke with told us that communication was effective within the team. One member of staff said, "We do work together well, we are a good team." Systems were not clearly in place that would ensure that people received consistent care when they transferred between services. For example, a hospital transfer form or similar was not used to support people when they were admitted into hospital. This did not enable people to receive care and support from staff that knew how to support them effectively.

People told us that they liked the food, but we saw they did not have a pleasant mealtime experience. Comments included, "The meal wasn't too bad today," and "The food is alright actually." We saw that there were varied menus at Melville House and that people chose the meal they wanted the day before. There were no menus for people to look at, the choices were discussed with people by staff. People told us that they got snacks and drinks but would like a wider range of foods. At our last inspection we noted that there were limited opportunities for people to eat at dining tables as there were insufficient numbers of tables. At this inspection we found this had not improved. We saw two lunchtimes and noted that many people sat in their armchairs to eat, as there was insufficient space for people to all sit at a dining table. We did not see that lunchtime was a pleasant or sociable mealtime experience as people ate without conversation or interaction. Records showed that health care professional were involved in supporting people with specialist diets such as pureed foods and supplements. We found that meals were a functional rather than pleasant experience for people.

People were supported by various health professionals, but staff could not tell us how people were involved in their own healthcare. One person told us, "The GP comes in when I need him." A relative told us they felt confident that the home would meet the health needs of their loved one. We reviewed people's health records and saw evidence of referrals to different medical professionals to promote people's health. We

spoke with one health care professional who told us that the staff had responded well to their suggestions to assist one person, but had not been proactive in planning ahead for that person's health and well-being. We found that referrals to healthcare professionals were not always made in a timely manner. For example, one person had deteriorating mental health that had been noted for several months. Support from a health professional had not been sought and when we brought this to the attention of the manager they assured us that appropriate referrals would be made.

The manager confirmed that a pre-assessment of people's needs was carried out before they moved into the home and this was confirmed by the relatives we spoke with. The pre-assessment helped the provider to find out if they would be equipped to meet the individual's needs before they moved into the home. People's needs had been assessed, but this was not always done well. Assessment processes had not involved people as much as possible, and people and relatives told us they did not recall being involved. Relatives we spoke with said they had been involved when people first moved into Melville House but not afterwards.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in March 2018, we rated this key question as 'requires improvement', because we found that the environment was poor and that the lounge area was crowded, which meant that people were not always treated with dignity. We also found that staff did not consistently show compassionate care for people. At this inspection, we did not find improvements and the rating remains as requires improvement.

The provider had not ensured that people were as involved in decisions about their care as much as possible. People's care plans did not contain information about how staff should support people to make choices about how their care was delivered. Relatives and people did not recall being involved in this process. Care plans included very basic information about people's religious, cultural, communication and other personal needs and preferences, but there was not life history information or other means of gathering information about what was important to people who lived at Melville House. The manager told us that they had begun a process of addressing this by focussing on one person every day. However, when we reviewed the process and the records of people who had been through it, we found that the person themselves was not involved.

Melville House did not support people to maintain their independence. People and relatives could not give us examples of being helped to become more independent. Staff we spoke with could not describe the methods they might use to facilitate someone to improve or promote areas of independence in their own lives. Activities that were arranged did not focus on independence. We did not see any examples of how people were supported to maintain their independence.

We received mixed views whether staff were kind and caring. We saw staff were busy and focussed on completing tasks and did not have enough time to engage with people and promote social interaction. One person said that, "It's OK here they treat me well." and another person said, "Most of the staff are kind, but not all." A family member said, "My relative is well looked after here." Another relative commented, "Some of the staff are friendly and some just do their job." The staff members that we spoke with talked about the people whom they supported in a positive, caring and respectful way. A staff member said, "The carers are really kind." We saw that staff interacted kindly with people while they completed various tasks, such as giving tea or taking people to the toilet. However, as in our previous inspection, we did not see staff taking time to interact with people when they were not completing care tasks.

People were not always supported to maintain a dignified appearance. We saw that one person was wearing glasses that belonged to someone else and staff had not supported the person to get their own glasses. A second person had very dirty finger nails. Another person sat in a wet jumper for the majority of the afternoon as they spilt drink from their mouth. The person was not supported to change their clothes until this was pointed out by one of the inspection team. Staff could not tell us what measures they might take to keep the person dry and comfortable such as wearing a clothes protector or changing their clothes frequently.

We saw that staff carried out personal care in private and were discreet when they asked people if they need

any assistance. We noted that the shared bedrooms had floor length curtains that minimised the issues around privacy for people in those bedrooms.

The registered manager and staff were aware of the need to maintain confidentiality in relation to people's personal information. We saw personal files were stored securely in the office and computer documents were password protected when necessary.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2018, we rated this key question as 'requires improvement', because we found that records lacked detail to provide staff with guidance and that the service was not personalised. At this inspection, we did not find improvements and the rating remains as requires improvement.

People and their relatives were not routinely involved in the decisions around their care and support, for example if they wanted to share a room or not. We saw that people's care records did not consistently include information about people's cultural, religious, language and communication needs. Although staff were able to tell us of those needs, documentation was not in place to ensure that people's needs were responded to in a consistent manner especially when being supported by new or agency staff. Care records did not contain information about the persons previous life history or things that were routinely important to them. People were not involved in decisions about their care and the care given did not consider peoples whole life needs.

At our last inspection we found people were not supported to take part in hobbies or interests, and that activities were limited. At this inspection people continued to have mixed views about the activities on offer within the home. One person said, "All we do is sit in a chair, the activities they do are boring." They told us and staff we spoke with knew that the person wanted to continue their hobby of 'tinkering' with mechanical objects. Although this was known about no action had been taken to facilitate this person's hobby. One relative said, "They do listen to me, they just don't do anything about it." Another person said, "I like to watch television and chat to my friend." We noted that while Melville had a part time worker to promote activities, people were not supported to follow their interests or be involved in wider social activities of their choice.

We did not see occasions where staff offered people individual activities to take part in, or spent time chatting with them. We observed throughout our inspection there were long periods of time where no activities or engagement from staff took place and we saw people spent time sitting and sleeping with little or no interaction. People did not have sufficient access to meaningful activities.

People and relatives told us there were no restrictions on visiting times and said they felt welcomed by staff at the home. We observed visitors were at the home throughout our inspection and we saw they were very welcomed by staff.

The Accessible Information Standard of 2017 defines a way of identifying, recording, and sharing people's communication needs. The standard aims to improve the health, care and wellbeing people receive by making sure they are communicated with in a way that suits them. This helps make sure that people can take part in decisions as much as possible. At Melville House we found that this standard was not being met. We saw that key documents about complaints and safeguarding were not in an easy to read format and that no other attempts had been made by the provider to make information for people more accessible.

The service had a complaints procedure and people that we spoke with told us that they knew how to make

a complaint. One person said, "I tell the staff if I'm not happy, they listen to me." A relative told us, "I would speak to the manager but I haven't seen a leaflet or anything." We looked at the complaints record and noted that there had been no complaints in 2018. We saw that in the reception area of Melville House there was a complaints folder with blank forms in for people or relatives to access. The manager told us that if they received any complaints they would try to resolve them as quickly as possible in partnership with the complainant.

We saw there were basic processes in place that ensures people would receive appropriate care at the end of their lives. Care records we looked at contained information relating to the medical care needs of people at this time, but did not focus on the social aspects of someone's end of life wishes, such as meeting their individual preferences with regard to cultural or religious requirements. Staff we spoke with did not have a consistent approach to how they would support relatives and friends during this time. We found that the plans to support people at the end of their lives needed to be improved.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2018, we rated this key question as Requires Improvement. This was because the provider did not have effective quality monitoring checks in place. We found there was a breach of Regulation 17, good governance. We imposed a condition on the provider's registration. This meant they had to complete an action plan to demonstrate the required improvements were being made. The action plans have been returned to us as required, but we found at this inspection that all the areas as specified for improvement within the breach had not improved. We have inspected this location on five separate occasions since April 2015, and have found that it was rated overall as Requires Improvement at all five inspections. At this inspection, we found sufficient improvements had not been made and the rating for this key question is now Inadequate. This demonstrated that the provider did not have systems and processes in place to make or sustain the required improvements.

During the inspection, we found the provider had not completed effective audits. Where audits were completed they were not identifying areas for improvement and issues of concern within the service. For example; care plan audits were completed but had not identified inaccurate or incomplete information about people's care needs. Audits had not identified that there were gaps in the MARS charts where body creams and medicinal patches had been given to people. Audits had failed to identify that the building was not maintained safely. Analysis of events such as falls had not taken place and the provider had missed opportunities to learn from these. As a result, issues were not identified and steps had not been taken to make improvements to the quality of the service and to reduce risks to people.

There were widespread and significant shortfalls in in how the service was led. The service lacked effective drivers to make improvements. The last five inspections undertaken by CQC had not resulted in sufficient improvements within the service. We saw that where actions had been completed these had been as a direct response to concerns raised with either CQC or the Local Authority and CCG. We saw that the manager was responding to these concerns, but we found that the provider was not proactive in making improvements such as a plan to make the home environment safe and comfortable and to have all the repairs completed in a timely manner. We found that there continued to be no clear strategy in place to improve the quality of care at Melville House.

The provider had not made sure that peoples' rights were respected. There were 'blanket rules' that inappropriately restricted peoples' choices about leaving the building. The provider had not ensured that staff had the skills and knowledge to act in accordance with the Mental Capacity Act 2005

This is a continued breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (1) Good Governance.

Providers and registered managers have a legal obligation to inform CQC about specific incidents such as allegations of abuse and serious injuries. They do this by submitting a 'statutory notification'. We found this had not been consistently done by Melville House and that they had not notified us of all the statutory notifications as required by law, for example one person had assaulted another person and this had not

been reported to us.

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

At our last inspection the provider had not routinely involved people in the running of the service. During this inspection we saw people and their relatives had still not had the opportunity to give feedback on the service they received. No one we spoke with had been involved in a resident or a relatives meeting. One relative said, "I went to one review about two years ago, but nothing since." One person told us, "Residents don't get a say really." The manager told us that people were not routinely involved in reviewing their care, and that a planned introduction of key worker system to assist with this had not yet started. The manager also showed us f a new 'Resident of the day' system that reviewed all aspects of peoples' care. However, we saw it did not involve the person themselves, or their relatives so that they could comment on how they wanted their care to be delivered. People and their relatives had not had questionnaires or a similar method of obtaining their views of the service and how it was run. We found that engagement with people was minimal.

At the time of our inspection there was a manager in place who was applying to us to become registered. 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. Staff told us that before the new manager started in May 2018, they had not been supported well, however they consistently told us that they felt things had improved when the new manager had started their job. One member of staff said, "If the manager knows about a problem, things get done." and "It's much better since the manager started, residents are getting new things like slippers and clothes."

Our inspection visit, and discussions with the manager identified that they understood their responsibilities and were working towards achieving those. There were clear lines of accountability within the service and staff were aware of their role and responsibilities. Staff were aware of and demonstrated their understanding of the provider's whistleblowing procedures. Whistleblowing is when a staff member reports suspected wrong-doing at work. Staff said they felt confident that if they raised any concerns the manager would listen and take the appropriate action.

Conversations with staff and records we saw demonstrated staff worked with other agencies such as doctors, district nurses and social workers to support the health and well-being of people. All organisations registered with CQC are required to display the rating awarded to the service. The manager had ensured this was clearly on display.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found that the management team had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively.