The Mellows Limited

The Mellows

Inspection report

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Loughton
Essex
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 April 2017 and was unannounced.

The Mellows is a residential service which provides care to older people, some of whom were living with dementia. The Mellows is registered to provide care for up to 50 people. At the time of our inspection there were 42 people living there.

This service was last inspected on 29 June and 01 July 2016, three regulations were not met and improvement was required. This inspection was carried out to check sufficient improvements had been made to the service.

The home is required to have a registered manager. 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager.

The service did not have a clear process in place to ensure people were always offered a choice of food and drink. People's nutritional needs had been assessed.

Where people who used the service lacked capacity to consent to care and treatment the appropriate steps were taken to protect their rights. Mental capacity assessments were completed and correct procedures were followed under Deprivation of Liberty Safeguards.

Staff were trained in the safe administration of medicines and had their competency assessed on a regular basis. Audits of medicines were carried out regularly and these were effective in identifying issues.

There were systems in place to ensure risks were assessed and steps taken to mitigate the identified risks. Staff were aware of how to recognise and report any allegations of abuse and had attended safeguarding training.

There were sufficient staff who had been recruited safely and who had the correct skills and knowledge to provide care and support in ways that people preferred.

Staff received annual appraisals, regular supervision and attended meetings to ensure they reflected on practice and were kept up to date with any changes.

The service had employed an activity co-ordinator who actively engaged with people individually or in groups. Care plans contained information about people's care needs, including their personal histories.

Quality assurance systems had been improved so that the service could be monitored and developed. There were arrangements for people who lived in the home and their relatives to be consulted about their opinions of the service.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were sufficient to meet people's needs.

People lived in a service where the premises and equipment had been improved to keep them safe.

People's risks were identified, assessed and managed safely. Clear guidance was in place for staff.

People's medicines were managed safely and people received them on time.

Is the service effective?

Requires Improvement

The service was not always effective.

Records reflected how people's capacity had been assessed and how decisions made in their best interests had been reached.

The service did not have a clear process in place to ensure people were always offered a choice of meal. People's nutritional needs had been assessed.

People received support from staff who knew them well and had the knowledge and skills to meet their needs.

People were supported to maintain their health.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful in the way that they supported and engaged with people.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

The service had employed an activity co-ordinator who actively engaged with people individually or in groups.

Care plans contained information about people's care needs, including their personal histories.

Complaints were managed satisfactorily and in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

People and their relatives were asked for their views about the home.

Staff felt supported by management.

The Care Quality Commission (CQC) were kept informed of any incidents at the service as required by the regulations.

A range of audits was in place to measure and monitor the care delivered.

The Mellows

Detailed findings

Background to this inspection

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

The inspection took place on 12 April 2017 and was unannounced.

Two inspectors and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had expertise in older people and dementia care.

We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including six care records, four staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

Some people could not tell us about what they thought about the home as they were unable to communicate with us verbally therefore we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to see that the way staff spoke and interacted with people had a positive effect on their well-being.

On the day of our inspection, we met with 12 people living at the service and spoke with three relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, seven care staff, the activity organiser and a visiting professional.

Good

Is the service safe?

Our findings

At our last inspection, we found that the premises and equipment had been improved to keep people safe but that the refurbishment was still to be completed. At this inspection we found that the refurbishment work had now been completed.

Staff told us they had received training in safeguarding and had a good understanding about the different types of abuse that could happen and the signs to look for. Staff were aware of the reporting process and told us they would go to their line manager or the registered manager if they had any concerns. At our previous inspection, it was noted that safeguarding concerns had been dealt with in line with the agreed procedures and appropriate referrals had been made to the local authority safeguarding team, but the registered manager and provider had not reported these concerns to the Care Quality Commission (CQC). At this inspection, all safeguarding concerns were reported to all relevant people including CQC.

People told us they felt safe living at the service. One person told us, "They look after me alright here – yes I feel safe, I'm looking forward to the hairdresser this afternoon." Relatives told us, "I have peace of mind, [person] is safe here" and "If I go away I know [person] will be fine, I do worry but the girls [care staff] are so good."

Staff told us they had seen the whistleblowing policy and would feel confident to report any concerns to the registered manager. One staff member said, "I would definitely say something, I couldn't go home or sleep at night if I didn't do it, what if it was your Mum?"

Risks to people were managed so they were protected. Care records contained a variety of risk assessments, which showed that people's risks had been identified and assessed as needed. Risk assessments contained detailed information and guidance to staff on how to support people safely. Risk assessments were in place for mobility and falls, tissue viability, moving and handling and nutrition.

Staff were aware of the risks to people of pressure ulcers and knew how to manage these. For example, people's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for this purpose and this included what equipment and care was required to minimise the risk. One staff member told us, "[person] broke their hip and is in a wheelchair a lot now so is at risk of pressure ulcers so we transfer from the chair to bed throughout the day to reduce the risk of them getting a pressure sore."

We found that the information in the risk assessments matched what staff told us, demonstrating that staff had up to date knowledge of the risks to people and knew how to manage them to keep people safe. We saw one person who spent all their time in room did not have access to call bell. Their relative told us they used to have one but it was gone now. However, when we looked at persons care plan and it stated, "The nurse bell is always at [persons] reach but they don't use it due to sight and hearing difficulties, [person] will call out when they need assistance."

Staff told us they shared information about risk at the daily handovers and by writing in the daily diary. One

staff member told us, "[Person] loves to be independent so will not always ask for assistance, we remind them to ask us for help so they don't fall." Another staff member told us, "We need to make sure [person] has their frame as they are at risk of falling."

There were enough staff to provide appropriate care for people. On the day of inspection two staff members had called in unwell and the senior had managed to cover these absences with other staff. Staff told us there were enough staff. One staff member said, "We have enough staff, we get time to spend with people."

Systems and processes were in place for the safe recruitment of suitable staff. Checks on the recruitment files for four members of staff showed that they had completed an application form, provided a full employment history and photographic proof of identity. The provider had also taken up references and undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use health and social care services.

People's medicines administration records (MAR) instructed staff on how prescribed medicines should be given, including medicine that should be given as and when required (PRN). These records showed that medicines had been administered as prescribed. Medicines were stored appropriately and the home had systems in place for the re-ordering and safe disposal of medicines. Staff training records showed that staff were trained on the safe administration of medicines. Medication was only administered by senior staff and audits were in place.

The service's premises and equipment were managed safely. Records showed that regular and comprehensive checks on the premises and equipment were carried out and appropriate action taken when required. Equipment such as hoists and scales were regularly checked and maintained by external contractors. A detailed monthly health and safety audit was carried out and each person had their own individual evacuation plan, which gave information to staff on how people needed to be supported in the event of an emergency, such as a fire, when the home had to be evacuated.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in June 2016, we found the service was not always effective; the registered manager did not follow the correct processes so that decisions could be made in the person's best interests where people lacked capacity. People's records did not always ensure people received consistent support when they were involved in making more complex decisions. We found instances where people's liberty and rights were restricted and relevant assessments of mental capacity had not been undertaken. After the inspection, the registered manager sent us their action plan setting out how they would address this shortfall. The plan included a more robust process in assessing capacity and following a best interest process. At this inspection we found the required improvement had been made.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Records showed people's mental capacity to make day to day decisions had been considered and there was information about this in their care plans. Clear processes were in place if people needed to make decisions about more complex matters, for example, whether bed rails were appropriate. This included access to an advocate and consideration by groups of people, such as relatives, health professionals, adult care services and staff. This helped to ensure people were supported to make their own decisions where possible, or decisions were made in their best interests by groups who knew the person well and could make fully considered decisions on their behalf. Where people had appointed a lasting power of attorney (LPA) about their finances or health and welfare, records were up to date and the registered manager confirmed the LPA would be involved in making relevant decisions.

The management and staff had good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had completed training. One staff member said, "I would help them with choices, show pictures and look at the person's reactions." Another staff member said, "We give people choices, to try to promote their independence, we give them two choices, if they cannot communicate, we rely on information given by family." A third staff member told us about a person who was unable to communicate verbally. We asked them how they communicated with the person, they told us, "We read the signs, look at the non-verbal communication; we also have instructions in the care plan; we repeat information, use simple sentences; keep trying, they will sometimes respond."

However, we observed inconsistencies in the way people were provided with choices about what they wanted to eat and drink. During our observation at lunchtime in the dementia lounge, people were poured orange squash and not offered a choice. We also observed staff put clothes protectors on people without asking their consent. Staff told us they were not sure how people had chosen their lunch but thought that the chef came round the day before. People were given plates of food, everyone had the same and they did not seem to know what it was. One person said, "What is it?" the staff member replied, "Diced chicken." Another person told us, "We never know what's for lunch, it's just put in front of us – there's no choice offered." A third person said, "Lunch is really good, and I enjoy all the food – I don't know what is for lunch today."

People were not offered a choice or any alternatives or given a description of lunch. No choice of dessert was offered either, when dessert came everyone got strawberry ice cream and strawberry sauce was already on the ice cream. One person said, "I didn't like the dessert, I like the cream coloured ice-cream."

We observed one person being supported to eat; the staff member sat at eye level and did not rush the person with their meal and regularly offered them water and refilled their glass. Another person did not eat any of their lunch. Staff did notice and on a few occasions verbally encouraged the person saying things like "Come on it will get cold" and "Eat your dinner [name] it will get cold." At one point a staff member offered the person physical assistance by putting food on fork to try to get person to eat, however they stood over them rather than sitting with them. A senior carer came upstairs to encourage the person, sat with them, had a nice chat, and asked, "Do you want something else." They then offered ice cream which person accepted and did eat. Staff were aware of this person was at risk of malnutrition. They were on supplements and later the senior checked with staff to see if they had eaten a good breakfast.

We also observed lunch in the other dining room and noted there was a nice atmosphere. Staff were attentive, there were flowers on the table, condiments, tablemats and cutlery, together with the view onto the garden. We saw that one person had a different meal from other people but again meals were served to people without any confirmation that this was what they had chosen. When we spoke to the chef, they told us that they did go round to people daily to ask what they wanted but did not ask upstairs as they thought the care staff did this, they also added on occasions when busy they did not always get time and they knew what people liked. We discussed this with the registered manager who told us that there are pictorial menus upstairs although we did not see these used on the day of our visit. The registered manager told us that they would address these issues with staff following this inspection.

The chef had detailed information about people's diets and systems were also in place to meet peoples' religious and cultural needs, for example, arrangements had been made to supply food that reflected a person's culture. We observed that one person with a gluten allergy was provided with an appropriate diet.

Record showed people's needs were assessed in order to identify their support needs regarding nutrition. Details of people's dietary needs, food preferences and likes/dislikes were recorded in their care plan. Daily food and fluid intake was monitored for people who were at risk of malnutrition. Records showed people's weight was monitored regularly and if there were significant changes, they would advise the GP.

Staff said they received an induction when they joined the service which included three days shadowing more experienced staff. This gave new staff the opportunity to learn about people so that they could meet their needs. One staff member said, "I learnt all about people when shadowing, I read their care plan summaries." During induction new starters were monitored and observed by senior members of staff to assess their skills and knowledge to ensure they were competent in their role.

The induction process also included training in mandatory subjects, for example health and safety, manual handling and food hygiene. Training also included topics that were relevant to the people who used the service, for example, dementia training. The registered manager kept a training matrix to monitor staff learning and ensure all mandatory training was up to date. We saw that the majority of training was up to date, where training was due the registered manager told us that this had been booked. Training for new staff with no previous care experience was based on the care certificate. The care certificate represents a set of standards which ensure care staff have a wide theoretical knowledge of good working practice within the care sector.

At our last inspection we found that the service did not provide staff with regular supervisions and

appraisals, which meant they were not fully supported to develop in their role. At this inspection the registered manager told us they kept a supervision plan to monitor that staff received regular supervision and an annual appraisal. Supervisions and appraisals are used to monitor staff learning and development and identify any training needs to ensure people were being supported by staff who had the necessary knowledge and skills. We saw an example of an annual appraisal of a staff member and found it was very thorough. It provided staff with an opportunity to discuss goals and objectives, training needs, their understanding of their role and identify their strengths and areas that required improvement.

We were told by people and their families that staff had the skills to meet people's needs. A relative told us, "Sometimes [person] can be aggressive; they deal with it really well they give him space then come back later." A person said, "They look after us all lovely here, it's a lovely place to live and we all have lovely rooms".

Staff confirmed they had supervisions and appraisals to talk about their performance and identify any training needs. One staff member said, "I have had one already, we talked about caseload, problems, how I've been doing, how well I am coping, the training I want to have." All of the staff we spoke with said they felt well supported. Staff said they had staff meetings monthly and this was an opportunity to bring up any issues and suggestions. Staff told us they were supported to undertake further qualifications in social care to develop their skills and knowledge.

We found that where poor practice was identified, the registered manager completed observational supervisions where actions were agreed to make the necessary improvements. For example, supervision had taken place where it was identified that a staff member had made a mistake with medicines. The agreed action was that the staff member would stop giving medicines and that additional training was arranged. Staff told us they had observational supervisions when an area of their practice required improvement. One staff member said, "I had supervision about medication, the registered manager checked and said I'm doing it well."

People were supported to maintain good health and to access healthcare services when required. Care records showed people received visits from a range of healthcare professionals such as GPs, district nurses, dentists, chiropodists, opticians and dieticians. One relative told us, "One time [person] cut their finger, they kept me well informed."

Good

Is the service caring?

Our findings

People and their relatives told us that they were well treated and the staff were caring. One person told us, "I'm very happy here and the staff are lovely, I don't know their names but they all look after me so well – I'm no trouble, well, I try not to be anyway." The person was cared for in bed and when we asked if staff supported them with their care needs, they added, "Oh yes, they're all lovely and gentle with me." Another person told us, "They're all good here – it's great, but I can't get used to being cared for. I used to do everything myself."

We observed a person talking with a staff member, the person said they wanted a pair of bright coloured leggings like the staff member was wearing and quite a laugh ensued. We observed many interactions of this nature during the day with first names used and staff had time to sit and chat with people.

We asked staff how they protected people's privacy and maintained their dignity when delivering personal care. One staff member said, "I keep the door closed, give people choices, ask what they want, explain things, close curtains and let people feel like are not being exposed."

Staff told us that they were keyworkers for people which meant that they took responsibility for making sure the person had a supply of toiletries, that their clothing was tidy and laundry completed and made sure the person's room was kept how they liked it. However, not everyone was happy with the laundry service. A relative explained that there was one staff member who was excellent and even ironed [family members] hankies but when that member of staff was not there the laundry service was not as good. The registered manager was aware of some concerns about the laundry service and did confirm that most issues occurred when the usual staff member was off duty, but they had recently increased staffing for the laundry and were monitoring this area.

Care records included information about people such as life history, hobbies, significant and memorable events, and likes and dislikes. This information helped staff generate discussions of interest and develop positive relationships with people. Staff were able to demonstrate that they knew the people well that they supported. For example, one staff member told us, "[person] likes to chat and joke, they're very cheerful and bubbly, and they go to the day centre a few times a week."

People were able to express their views and we saw that staff actively listened to people and sought to find solutions for the person. Regular meetings were held and a monthly questionnaire was completed at the meeting. Minutes of meetings contained actions, For example, people had expressed concerns about laundry going missing and the registered manager had increased the laundry hours.

Good

Is the service responsive?

Our findings

At our last inspection people told us that there was not enough to do. During this inspection we found that an activity organiser had been recruited. The activities co-ordinator had only recently started work but was already making a positive impact. They had developed good relationships with people and used people's first names throughout our observations. A coffee morning was taking place where the activity organiser had prepared cakes and biscuits and a large wicker basket of raffle prizes. Cakes were laid out on nice cake stands and everybody won something on the raffle. The activity organiser also took the raffle and cake basket around to people who stayed in their rooms.

The activity organiser told us that they planned activities day to day but would be preparing a schedule of activities once they had got to know what people wanted to do and had further discussions with the registered manager. They were enthusiastic about their role and had ideas for various activities they wanted to deliver. Although some people from upstairs had gone to the coffee morning there was not much going on in that unit but during the afternoon the activity organiser went upstairs and appropriate music was playing and people sang along.

We also observed a staff member helping a person to lay out a deck of cards and they were occupied with them for an hour after lunch. One person told us, "I was looking forward to a trip out last week, but there wasn't any room on the mini bus for me and I was told in the end that I couldn't go, the manager heard that I was upset and she arranged for the activities lady to walk me down town instead which I thought was very nice – I had a nice time out – that was nice of her." Another person said, "I prefer to stay in my own room and I look forward to doing the crossword in the paper each day and I have my own TV. I sometimes go out when my [family member] comes, I'm happy here, I'm safe."

The service organised religious events to meet people's spiritual needs and practices, for example, prayer, mass and Holy Communion took place in the garden lounge every month.

People had care plan summaries in their rooms which gave staff an overview of people's needs for quick reference. It included people's likes, dislikes, diet, interests and preferred routine. We saw that people's preferences were respected. For example, one person's care plan stated they liked to stay in their room and liked to have their curtains drawn back. We observed this was happening in practice. Records showed care plans had been reviewed regularly or as the person's needs changed. The plans had been updated to reflect these changes to ensure continuity of their care and support.

Staff we spoke with were familiar with people's preferences. For example, one staff member told us, "[Person] prefers food they can pick up and eat themselves as they don't like to be assisted." We looked at this person's care records and saw this was reflected in their care records.

We asked staff how they delivered person-centred care. One staff member told us, "We focus on the needs of the person, not generalising, tailor the care plan for their needs. We address them the way they want; it's about what they want, realising that everyone is different." They gave us an example of providing person

centred care in practice. "[Person] likes to get up and go to bed at different times, we respect that, when they want a cigarette we take them when they want, we don't wait for everyone else."

There was a policy in place for dealing with any concerns or complaints and this was made available to people and their families. Issues raised had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

Our previous inspection on 29 July 2016 we found that the provider had not met their legal obligations in reporting to the Care Quality Commission all safeguarding incidents which had occurred at the home. During this inspection we found that the new manager had taken steps to address these concerns and now met their legal obligations.

People and their relatives told us that they thought the service was well led. One person said, "They are very organised." A visiting health care professional told us, "It's a nice home, and there are nice staff here with a good manager – I've not seen any problems."

Staff were positive about the registered manager and the support they received to do their jobs. One member of staff told us, "The registered manager always listens, they are very good, and I feel well supported." Another staff member said, "They are a good leader, very approachable." Our discussions with people who lived in the home, relatives and staff and our observations during the visit showed there was a positive and open culture led by the registered manager and provider. Staff told us they felt confident in raising any issues and felt assured that they would be dealt with appropriately. One staff member said, "I feel supported, the manager is good, they address issues personally to you."

The registered manager and senior staff carried out regular audits to monitor the quality of the service and plan improvements. This included audits on equipment, fire safety, medicines and care documents. The audits benefited people as they resulted in improved practice. The senior staff monitored the quality of care by leading by example and observed what other staff were doing. They found observation whilst working with other staff helped them to identify good practice and challenge others when improvement was needed. Staff records showed us disciplinary action was taken if needed to address poor performance.

We viewed external audits had taken place by other professionals for example, a medication audit, a fire inspection and a local authority visit. All actions or recommendations had been addressed. The quality monitoring audit carried out by the local authority in 2017 rated The Mellows as 'excellent'.

There was an employee of the month scheme to demonstrate that staff were valued and encouraged staff retention which would benefit people, as they would be supported by a stable workforce. The staff team, combined with robust records and quality assurance systems ensured that the service was well led and that improvements in the service were a continuous process.

People could be confident that information discussed about them and held by the service was kept confidential. Care plans were available to the staff and were put away after use so that they were not left on display.