Four Seasons Health Care (England) Limited

# Melton House Care Home

## Inspection report

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Date of inspection visit:
09 May 2018
10 May 2018

Date of publication:
21 June 2018

## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

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

Melton House is registered to accommodate up to 32 people in one adapted building. At the time of our inspection there were 21 people living at the service. Accommodation is spread over two floors and there is a lift for people to move between floors.

There was currently no manager registered with the Care Quality Commission (CQC). However, a manager had recently been appointed and in post for three weeks. They told us they had submitted their application to register with CQC. 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.

At the last inspection in March 2017 the overall rating for this service was 'Requires Improvement'. At this inspection whilst we have acknowledged some areas of improvement this is the second time we have judged this domain as 'Requires Improvement' with an improving picture.

At our last inspection, we identified shortfalls relating to risks to people's safety. This was because the governance system had not identified or addressed certain areas. This included concerns about ineffective fire doors, a risk of burns from a hot water pipe and inconsistent staff knowledge and practice in relation to safe moving and handling practices. These shortfalls meant that risks to people's safety had not been identified and action had not been taken to mitigate these risks. We also found people were not protected from safe recruitment systems and processes in line with the provider's policy. There was a failure to gather all the information required to determine, as far as practicable, whether or not staff appointed were suitable for their roles.

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

We carried out this unannounced comprehensive inspection on the 09 and 10 May 2018. We found two continued breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we have acknowledged some areas of improvement, we found further work was needed to safeguard people from risks to their health, welfare and safety. Risks to people's safety associated with improper operation of the premises and the lack of investigations instigated from the monitoring of incidents had not always taken place. For example, where people had sustained unexplained bruising and skin tears

management audits did not always prompt further investigations.

Whilst staff were kind and caring in their interactions with people, there was a lack of effective system in place for the laundering of people's clothing. This demonstrated a lack of care and respect for people's belongings.

During our visits there were sufficient numbers of staff to meet people's assessed needs and the provider had improved and now operated safe recruitment procedures. However, further work was required to ensure the dependency tool used to determine the numbers of staff allocated to meet people's needs contained accurate information as to people's level of dependency. This meant that staffing levels may not always be matched to the level of need.

There were safe systems in place to safely store and ensure people received their medicines as prescribed. Staff were trained in medicines management and regularly had their competency assessed.

Staff received training and induction to their work. Further work was needed to ensure staff competency checks and training be provided in areas such as meeting the needs of people diagnosed with Parkinson's, those with in-dwelling catheters, people at risk of choking, pressure ulcer prevention and support of people living with dementia.

People spoke positively about the food and drinks they were provided with. People were given choice on a daily basis and were given food and drinks which they met their preferences. People who were at risk of not having enough to eat and drink were being supported and monitored. However, it was not always clear if this information was being analysed effectively, to ensure people's hydration needs were being fully met.

People and or their representatives, where appropriate, were involved in making decisions about their care and support. People's care plans had been tailored to the individual and contained information about how they communicated and their ability to make decisions about their everyday lives. However, care records did not always provide sufficient guidance to staff when people had indwelling urinary catheters and where specialist moving and handling equipment was required to ensure the care provided was safe, effective and met their needs.

The provider had a system in place to respond to people's concerns and complaints.

Staff, people who used the service and their relatives were all complimentary about the management team. They told us they found them approachable, engaging and had clear, person centred vision and values. People were comfortable to air their views and, provide honest feedback.

Following recent senior management structural changes we found there was a more open, transparent culture. There was now a clear and supportive management structure in place. Whilst we identified some shortfalls at this inspection, the provider had a vision for improving systems which evidenced their learning from incidents in their other services. They demonstrated they had clear plans to improve, innovate and ensure sustainability of the service.

## 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 always safe.

There were sufficient numbers of staff to meet people's assessed needs. However, further work was required to ensure the provider's dependency tool was accurate and fit for purpose in determining staffing levels matched people's needs.

Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks.

Risk monitoring tools such as Malnutrition Universal Screening Tool (MUST) and Waterlow assessments (pressure ulcer prevention) were not always correctly calculated.

The provider operated safe recruitment procedures.

There were safe systems in place to ensure people received their medicines as prescribed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had not always been provided with regular supervision.

Staff competency checks had not always been carried out and staff had not been trained to meet people's specific needs.

Staff sought consent from people before providing support. People's capacity to make decisions had been assessed.

People had access to health care professionals when needed.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Whilst staff were kind and caring in their interactions with people, there was an ineffective system in place for the laundering of people's clothing, which demonstrated a lack of

care and respect for people's belongings.

People were involved in making decisions about their care and were able to choose how they spent their time and despite some limitations felt in control of their lives.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care records did not always provide sufficient guidance for staff to ensure that the care provided was safe and effective.

People and or their representatives, where appropriate, were involved in making decisions about their care and support.

The provider had a system in place to respond to people's concerns and complaints.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Following management structural changes we found there was a more supportive, open, transparent culture.

Whilst there was a number of management audits in place the overall governance systems did not always ensure the safety and quality of the service was maintained.

Whilst we identified some shortfalls at this inspection the provider had a vision for improving systems which evidenced their learning from incidents in their other services.

# Melton House Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on the 09 and 10 May 2018 and was unannounced on both days.

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

Prior to the inspection, we reviewed information we had received about the service such as notifications. This is information about important events, which the provider is required to send us by law. We also looked at information sent to us by the provider and from other stakeholders, for example the local authority and health care professionals.

During the inspection, we spoke to nine people who used the service. We also spoke with five people's friends and relatives. Some people could not tell us their views about the care and support they received, 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 also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the homes manager, deputy manager, regional manager, three senior care staff and the supporting manager who was also the previous registered manager. We also spoke with the laundry assistant, five care staff, the cook and their assistant.

To help us assess how people's care and support needs were being met we reviewed the care records of five people who used the service including risk assessments, management of their medicines and monitoring charts in relation to care support provided. We also looked at staff recruitment files, staff training records, incidents and accident reporting and systems for assessing and monitoring the quality and safety of the

service.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection in March 2017 this key question was rated as 'Requires Improvement'. At this inspection whilst we have acknowledged some areas of improvement further work is required. We have judged this domain as continuing to 'Require Improvement' with an improving picture.

Policies in relation to safeguarding people from the risk of abuse and whistleblowing procedures reflected local procedures and relevant contact information. Staff demonstrated a good awareness of how to recognise people at risk of abuse and told us they would inform senior staff. However, not all staff understood or said they had been made aware of local safeguarding protocols, such as guidance for reporting concerns to the local safeguarding authority for investigation. The manager and regional manager were aware of their responsibility to liaise with the local authority if safeguarding concerns were raised. Following our feedback regarding gaps in staff knowledge the regional manager informed us of action taken to organise refresher training opportunities for staff.

We observed one person living with dementia walking with purpose around the building throughout our two-day inspection. They repeatedly tried to leave the premises via the front door. A person visiting told us, "I have to ring the bell to be let in the building and ask someone to let me out. There is always one person walking about and they will get out if they can." We saw an incident logged in the person's care records which stated the police had found them lost in the community and had returned them to the service. Staff had recorded they had last seen the person in the garden area and it was unknown how they had left the premises. The then registered manager had instigated 30 minute observations and made an urgent application to the local authority to deprive the person of their liberty. However, no risk assessment had been carried out with guidance for staff to mitigate the risk of this person going missing. Neither was a missing person protocol implemented.

We discussed our findings with the regional manager who immediately implemented an assessment of risk and put in place a nationally recognised multi-agency tool known as a 'Herbert' protocol in the person's care records. The Herbert Protocol is a nationally recognised information sharing scheme. A form containing useful information about a person is completed and shared with the police. This enables easy access to easily located, shared information and used in the event of a person with impaired cognitive ability such as someone living with dementia going missing.

Individual risks to people, such as continence management, the risks of choking, dehydration or developing pressure wounds had been assessed and management plans were put in place to minimise the risk of harm. These provided guidance to staff regarding what help people needed to stay safe, including regular monitoring, repositioning and application of creams. Although records were reviewed monthly, we found people's care records were not always updated outside of the monthly review and did not always reflect the current risks to their safety and wellbeing. For example, one person's 'quick glance care profile' had not been updated to reflect they had been identified as at risk of choking, due to swallowing difficulties in February 2018. Their nutritional plan had been reviewed and the instructions following Speech and Language Therapy Team (SALT) input had been included. However, this information was embedded within

the persons care plan and new staff or agency unfamiliar with them would not know from their profile they were at risk of choking.

A further example included the person who had left the premises unnoticed. Their 'quick glance care profile' had not been updated to reflect they were on initial 30-minute observations, reduced to 60-minute observations. This meant staff, particularly new or agency staff, not familiar with the person may not know to monitor. This placed them at risk of leaving the building unsupervised.

We observed one person being supported by staff to drink whilst being cared for in bed. They appeared to have difficulty with being able to swallow liquid without persistent coughing. We asked if senior staff had consulted the speech and language therapy team (SALT) for specialist advice. They told us the GP would not agree to refer people in receipt of palliative care. We were concerned and discussed this with the regional manager who immediately responded by ensuring a referral to the SALT team was actioned.

We found monitoring tools, such as dependency assessments, Malnutrition Universal Screening Tool (MUST) and Waterlow assessments (pressure ulcer prevention) were incorrectly calculated. These tools help staff to identify the level of risk to people concerning weight management and developing pressure wounds. Incorrect calculations meant that where people were assessed as at high risk of weight loss or developing pressure ulcers, they may not receive appropriate care and treatment to manage these conditions.

Staff were completing incident and accident forms for falls, pressure ulcers, weight loss and recurrent urinary tract and viral infections. However, the only incidents recorded on monthly management analysis were falls. The analysis form was not being used for its intended purpose to provide effective oversight of all incidents occurring in the service, lessons learned and any actions to mitigate the risk of reoccurrence. There was an additional box on the incident / accident form for near misses, which asked these questions, but this had not always been applied to the analysis of the incidents recorded. Although, individually people had been referred to appropriate health professionals concerning weight loss, pressure wounds and infections, there had been no analysis to identify if there were any underlying reasons as to why there were two outbreaks of infections, diarrhoea and sickness in first quarter of the year, unplanned weight loss and the number of people with skin tears and unexplained bruising.

Staff used moving and handling equipment safely whilst preserving people's dignity. Staff provided an explanation of the manoeuvre and reassurance. Hoists and slings used in people's rooms had been individually assessed and provided for people according to their needs to ensure their safe use. However, we found an open access sling attached to an electric hoist in the main dining room. Staff confirmed this sling was being used to support more than one person. The use of this type of sling for more than one person presented a risk of cross infection.

Not all care plans contained guidance for staff in the use of hoisting equipment. For example, to ensure they used the correct sling type with a description of the colour coded sling loop to attach to the hoist. This was important to mitigate the risk of people falling from the hoist. In response to our findings the regional manager informed that a review of all care plans was instigated to ensure these contained up to date information to guide staff in meeting people's needs.

There was a range of risk assessments, including but not limited to social activities, involving food allergies and specific diets, bathing using hoists, which referred to 'safe systems of work' (SSoW), and installation of tamper proof window restrictors had been completed to assess and mitigate risks to people. Hoisting equipment was regularly serviced and portable appliance testing (PAT) had been carried out to ensure that electrical equipment was in safe working order. Radiator covers had been fitted to cover radiators and

previously exposed hot pipe work. Fire doors were held open with equipment that automatically closed if the fire alarm sounded. Routine checks were taking place to ensure pressure-relieving equipment was working and set at the correct pressure for the person's weight.

Technology, such as sensor mats were used to alert staff if a person at risk of falls got out of bed to reduce the risk of injury from falling. A business contingency plan was in place with an up to date list of people, and details for staff on who to contact in an emergency such as a lift breakdown, gas supply failure or if residents needed to be evacuated, where they would be relocated.

Each person had a Personal Emergency Evacuation Plan (PEEP) in place providing guidance to staff on how to support them to evacuate the building safely in the event of an emergency. These however, contained minimal information, and referred to a person as a non-smoker, when their daily records referred to them as smoking. They also stated for another person that two staff were required to assist them into a hoist and then into a wheelchair. However, we found conflicting information in their care plan which stated they required four staff for all transfers.

The maintenance person provided us with records to reflect how risks in the service were monitored and managed to keep people safe. The estates folder contained a register of month-by-month maintenance checks to ensure systems were in place, which complied with health and safety legislation. The previous registered manager was listed as the 'responsible person'.

Although the provider had established systems in place to manage and respond to risk we found there was a lack of monitoring and oversight to ensure these arrangements were effective. For example, weekly checks of the fire system were completed to ensure it was in good working order. However, records showed no checks had been completed from 27 February to 06 March 2018 because the maintenance person was on holiday. The same applied to checks of fire doors to ensure they closed when the fire alarm sounded. Therefore, no checks had been made of fire system during this period. The previous 'responsible person' had signed the monthly checks off as completed.

In addition to checking the fire system, the maintenance person was completing checks on water temperatures, hot surfaces, nurse call system, window restrictors, wheelchairs and fans using a tick box or signature sheet. Although, there was a form to record any defaults or action required to address issues and make improvements they were not using these to reflect if any remedial works were required or carried out. For example, we identified a fire exit would not open and was locked shut. The manager told us the door needed a new mechanism and this had been ordered, however this was not reflected on the action log to reflect how long the door had been out of action and the risk to people exiting the building in the event of a fire. In response to our findings the regional manager informed us action had been taken to set up daily meetings between the manager and maintenance staff to review record keeping and review updates in relation to ongoing maintenance.

A private company on the request of the provider completed a fire risk assessment dated 25 July 2017. The assessment identified a number of areas requiring improvement, which included fitting intumescent strips, smoke seals and detectors in a number of cupboards, rooms and the doors to the laundry. The door to the storeroom cupboard on the first floor required a fire door and a fire detector needed installing in the roof compartment accessed by loft hatch in hairdresser's salon. We checked these actions with the estates project manager who confirmed these remedial actions had not been undertaken. Following the inspection, the area manager informed us the fire risk assessment was fully reviewed and remedial work has been arranged.

The arrangements in place for the ensuring the premises were clean were not always effective. Although people's bedrooms, communal areas, the stairs and landings were clean and tidy, the floor, shelving and equipment in the main kitchen was not clean, despite being 'ticked' as cleaned on a daily basis in cleaning schedules. The Food Standards Agency (FSA) had given the service a food hygiene rating of five at their last visit 02 February 2017 with no follow up actions. The Food Standards Agency is an independent Government department, which rates services reflecting the standards of food hygiene, five being the highest. We found two rooms leading off the kitchen being used to store food along with two cleaning trolleys with buckets containing dirty water and mops. We found cakes partially covered, exposing these food items. No date of when these items had been made had been placed on the covering. A sponge cake was standing on top of a box of potatoes; another was standing on top of box of oil on the floor. Boxes of gluten free cakes had been opened, and some cupcakes exposed had gone dry and hard. Shelves contained a range of foods, in no order. Vegetables and fruit, (bananas and onions) were mixed in with tins of foods and jams. Packets opened, such as mixed fruit had no seals. Some packets, such as cornflakes had been purchased in bulk and packaging with dates had been discarded therefore no expiry dates available. We also found six containers, one with no lid of prescribed drinks thickener mixed in a container with other dried food items.

We found the doors to the laundry facilities were not locked, despite having key coded locks fitted to prevent people, particularly those living with dementia and at risk of harm accessing these facilities. The codes were available for staff to use, but each lock had been left on the latch. Although there were separate rooms for clean and dirty areas, these were not adequate as the washing machines were plumbed in on entering the dirty room, with tumble dryers situated at the rear end of the room, which meant bringing laundered clothing passed the dirty area to take into a separate room for airing and ironing.

We discussed our findings in relation to the laundry with the manager and regional manager. They told us and confirmed in writing plans in process to relocate the laundry with funding agreed by the provider but with as yet no timescales for starting this work.

We saw during the two days of our inspection there were sufficient numbers of staff to meet people's needs. Staff responded to call bells in a timely manner and had time to sit and chat with people. All of the staff we spoke with said there was sufficient numbers of staff during the day time but would benefit from more staff available between 05:00am and 08:00am to support people who wanted to get up at a time of their choosing. People told us they were supported to get up at a time that suited them. A visitor to the service told us, "Staff tell me sometimes they are short staffed, I did come in one day and they had three instead of four staff on duty, but I think the member of staff had to leave due to personal circumstances. Staff are fine can't fault them they are lovely, I am grateful for what they do."

The provider used a dependency assessment tool to determine staffing levels according to people's needs. Senior staff reviewed care plans monthly and used this information to consider how many staff would be needed. We found contradictory information and could not be assured that staffing levels had always been adjusted to reflect increasing risk. For example, when people's needs changed and they required additional support from staff to be cared for in bed or when the number of staff required to support one person to mobilise in a hoist increased from two to four staff.

One member of the catering team told us, "I feel we have enough staff to prepare, cook and clean the kitchen. We have two cooks who work flexibly to cover each day of the week, supported by a kitchen assistant."

At our last inspection we found the provider had not carried out appropriate checks prior to staff being employed. At this inspection we found three staff employed since our last inspection had all relevant checks

in place. This included references obtained from the most recent employer, the person's identity confirmed and checks obtained through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions.

Medicines were managed safely and people received their prescribed medicines on time. There were systems in place for the ordering, safe storage, administration and disposal of medicines including controlled drugs. Information about what people's medicines were for and how they liked to take them was comprehensive and made clear to staff. Protocols were in place for 'as and when required medicines' (PRN) such as for pain relief. People told us their prescribed medicines were made available without delay.

We observed a drugs round and noted that people were asked about pain relief as a matter of routine. People told us, "I do receive my medicines regularly", "They arrive on time mostly and they watch me take them" and "If you want something to take away the pain you just pull the buzzer and they don't take long to sort you out." However, further work was needed to ensure people maintained their independence in the management of their medicines. For example, one person using the service for a period of respite managed their own medicines at home but was having their oral medicines administered by staff even though their assessment of need demonstrated they were more than able to continue to do so.

We carried out an audit of stock against medication administration records. We found that these tallied. Body maps were used to indicate the site for application of prescribed creams, lotions and transdermal patches for pain relief. Records had been made to indicate where on the body transdermal patches had been applied to ensure alternate sites were used at each administration.

All staff who administered medicines had received relevant training and their competency was checked regularly to ensure their practice remained safe and effective.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection in March 2017 this key question was rated as 'Requires Improvement'. At this inspection whilst we have acknowledged some areas of improvement further work is required. We have judged this domain as continuing to 'Require Improvement' with an improving picture.

Staff worked well together to ensure they delivered effective care and support to people using the service. Staff told us, working as a team ensured people received care in a consistent way. Handover meetings took place between shifts to support effective communication regarding people's up to date needs were communicated to staff.

The regional manager told us that staff should receive supervision support at least six times per year and annual performance appraisal. Supervisions and appraisals were used to monitor staff performance and plan for training needs and any additional support needed. We noted from a review of records and discussions with staff, supervision support had not been provided. This meant that staff had not always been provided with the opportunities to discuss their training and development needs. The new manager told us they had identified this shortfall and one of their priorities was to improve the provision of supervision meetings for staff. A supervision timetable was now in place and ready to commence from the 17 May 2018.

Staff received training and induction to their work. Staff told us that the majority of training they received, other than moving and handling was via e-learning. Staff told us they would prefer face to face training as one told us, "I learn better from discussion and interaction with others. Sitting in front of a computer is not ideal it does not stay in my brain." We found some shortfalls in staff knowledge and understanding which did not currently have a significant impact on people, but it could do if left unaddressed in the future. For example, staff competency checks and training in areas such as meeting the needs of people diagnosed with Parkinson's, those with in-dwelling catheters, people at risk of choking, pressure ulcer prevention and support of people living with dementia.

Catering staff told us they had received training, Which gave them the knowledge, skills and confidence to carry out their roles. Training had included, moving and handling, safeguarding, food hygiene, fire safety and Control of Substances Hazardous to Health (COSHH). However, one of the cooks could not remember if they had completed infection control and had limited knowledge regarding this subject.

The décor inside and out of the service was looking tired and needed refurbishment. Toilets and bathrooms were bare and clinical looking with no homely features. Showerheads had a build-up of scale on them posing a risk of containing harmful bacteria. People's personal toiletries had been left in bathrooms. The courtyard garden and rear garden was overgrown. The rear garden accessible via the fire exit (next to staff room) has no gate separating the maintenance shed, containing tools. A selection of old metal frames was on the grass outside the shed alongside containers, one with a lock not secured. The garden gate was unlocked and led out to the road at the front of the building. The estates project manager visited the service on the second day of the inspection and confirmed a gate was to be installed separating the maintenance

area and external gate to make the rear garden enclosed and safe.

The manager told us they were provided with a budget to redecorate service and said they were aware the service needed some refurbishment. They also told us the organisation was making a bid to the Dementia Care Framework to access grants to refurbish the service to enhance the environment for people living with dementia.
A visitor to the service commented, "The outside of the home looks scruffy and untidy, it needs a jolly good sweep to clear cobwebs. The plant pots are a waste of time, some are broken and they are overgrown with weeds." The manager described plans they had to improve the outside garden areas including a sensory area to enhance people's enjoyment.

People's bedrooms had been personalised. Adaptations had been made to the building enabling people to move freely around the premises, including those who used wheelchairs. Handrails were situated in all corridors and we observed them being using these to help move around the service safely.

We observed the lunch time meal on both days of our inspection. Where people required additional assistance, this was provided in an engaging and patient manner. Staff were attentive and the dining experience for people was enhanced with jovial interactions. Alternative meal options were offered to people if they did not want the main options on offer.

People were positive about the food provided. Comments included, "The food is good, there is plenty of it." And "The food is very good, if I don't like what's on offer they find me something else" and "I have no complaints the food is more than adequate for my needs." A hydration station with sugar free squash was available for people to help themselves throughout the day.

One of the catering staff told us, they did not keep a record of what people had eaten, or what was returned to the kitchen. They said, "Most people were fairly good eaters." They were however aware of people who won't eat if portions are too big and preferred smaller plates. The catering staff were aware of people's food preferences and including the use of fortified food, snacks and milk shakes for people underweight. However, they did not have a good understanding of a diabetic diet, other than not having sugar. Carbohydrates have a big impact on your blood sugar levels, more so than fats and proteins. People need to careful about the types of carbohydrates they eat. Refined carbohydrates like white bread, pasta, and rice, as well as soda, candy, packaged meals, and snack foods need to be limited. Full fat dairy, fruit juices and dried fruit are also to be avoided.

One of the cooks told us they organised a four-week menu, which changed seasonally, in spring, summer, winter and autumn. The cook told us the menu was based on their knowledge of peoples likes and they tried to provide a happy medium. They told us they received feedback from the manager following resident / relatives meetings that people were happy with the food. We also observed catering staff go round after the midday meal to ask people if they were satisfied with the meal that had been provided.

Catering staff told us the communication between managers, staff and the kitchen was good. If people's needs changed they were informed straight away, for example, they were aware that a person had recently been diagnosed at risk of choking and now required a soft diet.

We observed people were encouraged to drink during and in between meal times and were offered a selection of snacks and drinks throughout the day.

People's records confirmed they had access to a range of healthcare services including GP's who carried out

a weekly surgery at the service, optician, community nurses, physiotherapist, and dietician. People's care records contained information that showed they were referred to appropriate professional support regarding ongoing care, support and treatment, such as the falls prevention team, dietician and SALT team. We saw one person had been referred to the mental health team due to a decline in their memory and who had recently been diagnosed with dementia.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager and some staff had a good understanding of the MCA and DoLS. People were supported to have choice and control of their lives and staff understood how to support them in the least restrictive way possible.

We saw that people's ability to make decisions was assessed in line with the Mental Capacity Act 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Care plans contained information which considered whether or not people had the capacity to make decisions about their health and welfare. Assessments had been carried out to establish if DoLS applications should be made for people living at the service. We saw some DoLS applications had been submitted for some people to the local safeguarding authority. However, there was no information in care plans to show that the previous registered manager had been in contact with the local authority to chase outstanding applications for a response.

The provider had clear procedures in place for staff to follow when people were not able to make decisions about their care or treatment. These included making decisions in people's best interests on a day-to-day basis, such as providing personal care and continence management. For decisions that are more specific, we saw that appropriate qualified professionals had been involved in making best interest decisions. For example, one person's care plan reflected they had fluctuating capacity with guidance for staff to ensure this person was given opportunities to make choices and decisions for themselves. For significant decisions they were supported by an independent advocate.

Requires Improvement

# Is the service caring?

## Our findings

At the last inspection in March 2017 this key question was rated as 'Good'. At this inspection the rating has been judged as 'requires improvement'.

Whilst staff were kind and caring in their interactions with people, there was a lack of effective system in place for the laundering of people's clothing which demonstrated a lack of care and respect for people's belongings. We saw a large rack full of unlabelled clothing hanging up and another large pile of clothing along one side of the laundry room. Laundry staff told us they were unable to identify who these clothing items belonged to, had not been able to do so for a significant period of time and so these had not been returned to their rightful owner. This meant we were not assured that effective systems were in place to ensure appropriate action had been taken to respect and care for people's belongings. A visitor to the service told us, "I do [Person's] washing, as they had three pairs of trousers ruined, many clothes all go into together. This is disrespectful of people's belongings."

We observed one person cared for in bed was provided with a liquidised meal due to an identified choking risk. The person asked the member of staff supporting them to describe the meal they were about to receive. When told it was chicken and mushroom pie, the person said they did not like mushrooms. The member of staff responded, "Well let's just give it a try." The inspector who was present at the time checked with the person who once again said, "I do not like mushrooms, I have never liked mushrooms." The member of staff only then when promoted by the inspector went to find an alternative meal.

We observed a culture amongst staff where there was genuine care for people where they were treated with dignity, respect and compassion. Staff were friendly and patient when offering or providing support to people. We saw lots of positive interactions with laughter. One person said, "They are all lovely here. We have a laugh and all get along very well. You cannot get better." And "I have nothing but praise for them. They are so friendly and helpful." A relative told us, "The care here is very good. I have no complaints. It feels like family here, I am made to feel welcome and allowed to join in when they do have entertainment. My only comment would be that they need more to do, people tell me they get bored."

We saw positive interactions between staff and the people they supported. They were friendly, affectionate and showed concern for people's wellbeing. For example, we overheard some nice engagement between a member of staff and a person using the service about their favourite chocolate. The person said, "Maltesers dear", the carer responded by saying, "I will get you some on the way home from work and bring them in tomorrow." When the person said about money the carer responded, by saying, "No need, it's my treat."

People were treated with dignity when they required support from staff to mobilise and use the electric hoist. This was carried out in a dignified manner. We saw other positive examples where staff respected people's dignity, for instance, a member of staff approached a person in the communal lounge, and spoke with them quietly to support them to go with them to change their clothing where they had been incontinent. We also saw staff gained people's consent to enter their rooms and provide personal care. Staff knocked on people's doors whether or not they were open or closed, rather than just walking in.

People were clean, dressed in appropriate clothing, their nails, hair and their glasses were clean. One person told us, "It is so important to have your hair done regularly and here they have a hairdresser come in once a week. I look forward to having my hair done, it boosts your confidence."

People told us they were provided with daily choices as to how they spent their time and despite some limitations felt in control of their lives. One person said, "I am an early morning and early to bed person and they know this and respect this." Another told us, "I've never felt rushed and they know I prefer female carers to give me a wash and I have to say most of the time this has been the case."

We asked people whether staff spoke to them in a respectful manner and supported them in line with their preferences. Everyone we spoke with said staff were respectful and addressed them by their chosen name and staff would enter their room after knocking to respect their privacy.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection in March 2017 this key question was rated as 'Requires Improvement'. At this inspection we judge this domain as continued 'Requires Improvement'.

People and or their representatives, where appropriate, were involved in making decisions about their care and support. People's care plans had been tailored to the individual and contained information about how they communicated plans to achieve people's goals and aspirations and their ability to make decisions about their everyday lives. We saw that some people had signed their care plans to evidence their involvement and agreement with its contents.

Supporting plans and assessments had been written detailing how staff were to support the person and to mitigate risks to their health and wellbeing. Care plans were being reviewed monthly. One person's care records showed they had lost weight and referred to the dietetic service. Their care plan reflected a dietetic nurse completed an assessment of their needs and recommended a diet plan. Because the person was eating a fortified diet with added calories in foods such as cream, butter, and milk to their meal and drinks, plus snacks they had steadily gained weight.

However, we found where people had indwelling urinary catheters in situ, care plans did not provide clear guidance for staff as to the required regularity of catheter bag changes and or accurate records of when these had taken place. Without clear guidance and checks, this has the potential of putting people at risk of urinary tract infections (UTI). Catheter associated infections can be a problem in long-term care such as care homes, where older people who may be catheterised for prolonged periods are consequently at risk of recurrent UTI's and complications associated with infection.

Where mobility equipment was required, we found the quality of information provided in care plans varied. For example, we found where staff were required to use hoist lifting equipment, there was not always guidance provided to ensure staff used the correct sling type with a description of the sling loop to attach to the hoist. This was important to mitigate the risk of people falling from the hoist. One person's care plan contained conflicting information as to the numbers of staff needed to mobilise using the hoists and turning in bed safely. We discussed this with the manager who reacted promptly to rectify this.

There was a complaints process in place. Not all of the people we spoke with were aware of this. However, we found a clear system for logging concerns, suggestions and complaints. We noted that all concerns and complaints had been taken seriously and responded to in a timely manner with a clear audit of actions taken in response to concerns.

People said that they were supported to voice any concerns they might have and the manager had been supportive in listening to suggestions they had made to improve the service through residents meetings and satisfaction surveys.

People's wishes and preferences in planning for the end of life care were in place. Advanced care planning

documents had been completed setting out people's preferences for end of life care, including their spiritual and religious beliefs and arrangements after their death. For example, one person stated they wanted to stay at Melton House.

Where agreed, people had a Do Not Attempt Resuscitation (DNACPR) order in place. A DNACPR form is a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR). However, we recommend that these are reviewed regularly with the person and or their representative to ensure they reflect people's current wishes.

People expressed mixed views about the support they received to follow their interests and participate in social activities. A vacant activities coordinator post had recently been recruited to with a start date planned shortly. People told us there were limited group and one to one activities on offer. We noted the gardens did not enable people easy access to enjoy the outside. One person told us, "I have always enjoyed the outside and have led an active life, sitting around all day is not for me." Another said, "We do sometimes have entertainers come and sing and play but most of the time we sit and watch TV. It would be so much better to have things to do, you know to keep your brain occupied and pass the time of day." A relative told us, "Yesterday there was a lovely birthday party going on but lately not much in the way of activities, it is a shame to see people sat around bored. The staff try their best, they play bingo sometimes and last week there was a gardening event going on where we planted up hanging baskets. Let's hope the new activities person coming will make the difference. The manager confirmed the recruitment of an activities organiser who was due to start their employment within the month.

Requires Improvement

# Is the service well-led?

## Our findings

At the last inspection in March 2017 this key question was rated as 'Requires Improvement'. At this inspection whilst we saw some improvement we have judged that the rating to remain as 'Requires Improvement'

A new manager had been in post for three weeks. They told us they were in the process of making an application to CQC to become the registered manager for the service. They told us they had received a lot of support from the regional manager and resident experience support manager. They had attended a two-day induction to learn about the company and systems in place for managing the service.

We found some improvement with lessons learnt from incidents in another of the provider's services, which had led to changes in the management structure and additional oversight and support was now provided. A new regional manager had been appointed. Regional managers had fewer services to monitor and their presence and support was much more visible. There was a clear management reporting structure in place. Staff were aware of their roles and that of the management team.

There was an open, transparent culture evident from our discussions with the manager and regional manager. Whilst we identified some shortfalls at this inspection there was an immediate response to rectify issues where they were able to do so. The provider had a vision for improving systems which evidenced their learning from incidents in other care services they provided. They demonstrated they had clear plans to improve, innovate and ensure sustainability of the service.

Whilst there was a number of management audits in place the overall governance systems did not always ensure the safety and quality of the service was maintained. Risks to people's safety associated with improper operation of the premises and investigations instigated from the monitoring of incidents had not always taken place and action taken to mitigate people from the risk of harm. For example, where people had sustained unexplained bruising and skin tears, management audits did not always prompt further investigations.

We reviewed the accident and incident reports and the previous manager's monthly analysis. We found these had not always been used effectively to identify trends, such as repeated falls, incidents of skin tears and unexplained bruising. The action taken to address these had not historically always instigated investigations with outcomes and actions to prevent further incidents, or identify if additional staff training was required.

Staff, people who used the service and their relatives were all complimentary about the management team. They told us they found them approachable, engaging and had clear, person centred vision and values. People and staff said they felt comfortable to air their views and, provide honest feedback. When asked what they would like to see improve the quality of care they received, people told us, "We need more to do. We have been told a new person will be starting soon to get us back to some organised activities, it can get very boring at times." Another told us, "I'd tidy up the outside of the home, first impressions make a

difference and it's a bit scruffy. Having said that, one of the first things the new manager did was change the seating area opposite the entrance. There used to be a sofa and it didn't give a great impression as you walked in."

There were clear lines of accountability for staff, We saw policies and procedures, which set out what was expected of staff in terms of their performance and guidance to protect people's health and welfare and mitigate them from the risk of harm. The provider's whistleblowing policy supported staff to question practice. It also assured protection for individual members of staff should they need to raise concerns regarding the practice of others.

The manager had held a couple of staff meetings setting out their expectations from staff and the vision for the type of service they wanted to deliver. Staff told us the new manager was, "Approachable" and "Easy to talk to." One member of staff told us, "I feel we now have a really caring staff team and I would have any relative of mine live here. The new manager is lovely; I feel she cares about the home. Everybody helps each other; we are a team, like a family."

Recent resident and relatives meetings had taken place to introduce the new manager. People and their relatives told us overall it was a positive meeting and issues concerning laundry and the need for more social activities. The manager told us they were aware that improvements to the service were needed and sited plans for significant changes to relocate and implement systems to ensure better management of the laundry, was a priority.

We found the manager and staff team sought to provide consistent joined up care for people by working collaboratively with other agencies. This included engagement with a range of health professionals such as the local surgery, community nurses, chiropodists, speech and language therapists and social care professionals. This meant staff sought support from other specialists to improve outcomes for people.