

Melrose House Cullercoats Ltd

Melrose House

Inspection report

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Date of inspection visit: 3 and 4 November 2015
Date of publication: 11/01/2016

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

Melrose House provides personal care and accommodation for adults with mental health needs or a learning disability. The home can accommodate up to ten people. At the time of our inspection nine people were in receipt of care and support from the service.

The inspection took place over two days, 3 and 4 November 2015 and was unannounced. The manager and one care worker were on duty throughout the duration of the inspection. The manager had been in post

since July 2014 and was in the process of applying to the Care Quality Commission to become the registered manager of the home. The service has not had a registered manager since July 2014.

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.

Summary of findings

People spoke highly of the manager and the care workers who supported them to live independently at the service. People told us they felt safe and secure. They informed us that they felt well-cared for, happy and relaxed.

Policies and procedures were in place to safeguard people from harm or abuse, however there was no effective system in place to record any incidents or monitor trends. This could mean that reoccurring incidents were not investigated properly or managed effectively. The manager informed us that they were aware that all the service's policies and procedures were in need of updating.

People told us about a variety of activities and clubs they attended in the community. Most people actively accessed the local community themselves and we observed people going out shopping for items for the evening meal. The home had recently celebrated Halloween and people told us how they had been involved in decorating the home and had worn fancy dress costumes, which they enjoyed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The manager told us that nobody living at the home had any restrictions placed on their liberty in line with the Mental Capacity Act 2005.

People told us they received their medication in a safe and timely manner. We observed staff following the medication procedure correctly and people receiving their medication as prescribed. Medication was stored safely and securely and records were concise and up to date.

People were supported by the service to maintain a balanced diet. Menu's contained a variety of options and people could choose for themselves. We observed people enjoying an evening meal in which one person had been involved in preparing with staff.

Overall, people's care needs were assessed and the service had considered risks associated with these needs. The staff had a good knowledge of the care people required. However, care records were adequately detailed and the manager had not considered the risks associated with people accessing the community. One person had not had risks associated with their mental health condition assessed and measures were not in place to mitigate these risks as much as possible.

There were sufficient staff employed to manage the service and all had been employed for longer than nine months. Staff had received a variety of training and had either completed or were working towards qualifications in health and social care. The manager carried out regular staff supervision and appraisal meetings which confirmed they all took an active part in these meetings.

Staff vetting procedures were not robust with unexplained gaps in employment histories and references not always obtained from potential new staff's previous employers. Evidence suggested that Disclosure and Barring Service (DBS) checks had not been carried out and checked appropriately.

The building was in a relatively good state of repair and decoration. Individual bedrooms and communal bathrooms were not clean and were in need of some attention. The kitchen extension to the rear of the ground floor was well equipped and well used by people living at the service.

We found that several mandatory premises checks were not up to date. We brought this to the attention of the manager during the inspection and she acted upon our concerns straight away.

We found a significant number of events where the police had been involved had not been notified to us.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Safeguarding procedures were not being followed correctly as safeguarding incidents and accidents had not been recorded or reported as required.

The manager had placed a restriction people's bedtimes which does not promote their choice and human rights. Individual risks people faced were not appropriately assessed or documented.

An overall risk assessment of the premises and equipment was not up to date, meaning several mandatory checks had not taken place. Bedrooms and bathrooms were unclean and in need of basic repairs.

Staff pre-employment checks were not robust.

People told us they felt safe living at the home and they received their medicines in a safe and timely manner.

Requires improvement



Is the service effective?

The service was effective.

Consent to care and treatment was sought in relation to people's care and treatment. People had some involvement in their own care planning.

Staff were knowledgeable and suitably qualified and were supported by the manager through supervision and appraisal.

People were supported to maintain a balanced diet and records of dietician involvement was seen in care plans. People looked happy and healthy.

People's general healthcare needs were met and the service involved other health professionals when appropriate.

Good



Is the service caring?

The service was caring.

Staff interacted well with people and displayed positive and caring attitudes. They understood people's needs and responded to these efficiently. Staff knew about the people and their past lives.

There was plenty of choice around food and activities. People were involved in making decisions about their daily care and support.

Staff treated people with dignity and respect and had an understanding of equality and diversity and encouraged people to be individual.

Staff were caring and supported people well. People were asked for their views when decisions needed to be made.

Good



Summary of findings

Is the service responsive?

The service was not always responsive.

Care records were individual and people's needs were assessed. However, care plans and risk assessments were basic in detail and in need of updating. Some care plans contained out of date information. In one case care plans and risk assessments had not been drafted at all.

A complaint policy was in place and the manager told us she had received no complaints or concerns.

People were aware of how to complain and said they would feel comfortable raising any issues that they may have with the manager or any of the staff team.

Requires improvement



Is the service well-led?

The service was not always well led and is without a registered manager.

The provider did not demonstrate good governance. There were no records in place to monitor safeguarding concerns, accidents or other incidents. We identified 24 incidents which had not been notified to CQC.

Audits and checks were not taking place to monitor the quality and safety of the service or to drive improvements. This included checks of the premises, equipment, care records and staff files.

The provider visited but there were no records to support what had been reviewed.

Stakeholder surveys had been carried out; however no subsequent action plan had been devised to address any issues which had been raised. Action plans were not in place to address daily concerns raised between different staff teams during handover between shifts.

Requires improvement



Melrose 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 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 3 and 4 November 2015 and was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection we reviewed all of the information we held about Melrose House including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

In addition, we contacted North Tyneside Council's contract monitoring team, the safeguarding team and the community learning disabilities team to obtain their feedback about the service. The safeguarding team informed us of one safeguarding concern which they were aware of. This enabled us to investigate the way the home recorded safeguarding incidents. All of this information informed our planning of the inspection.

During our inspection we spoke to all nine of the people who lived at Melrose House. We spoke with one care worker and the manager who were both on duty. We also spoke to a community psychiatric nurse (CPN) who was visiting someone during the inspection.

We pathway-tracked six people. This meant we reviewed all elements of their care, including inspecting their care records, daily diaries, medication records, finance records and observing the care that they received

We looked at all of the staff members' files, apart from the manager's as this was not available on-site.

Is the service safe?

Our findings

We identified breaches of regulations in respect of the management of infection control risks, maintenance of the premises, safeguarding people from abuse and staff recruitment.

People told us that they were responsible for cleaning their own rooms. The manager and staff told us that they encouraged and supported people to keep their rooms clean. The majority of the rooms we visited (with people's permission) were unkempt and dusty. In one care record dated 2 November 2015, staff had documented "Assisted X to clean room. Cleaned floor". We observed this person's room and the floor was dusty, marked and sticky. There was thick dust and hair around the windowsills and the sink area was stained with toothpaste and soap residue. Other rooms that we viewed had a strong smell of tobacco smoke, vanity cupboard cabinet doors and handles were dirty and in need of cleaning and light switches had dirty finger marks upon them.

In the corridor we observed brown staining on the wall near a handrail outside a bedroom. We noticed that this led back into a person's bedroom and was on the sink. Although the staff member used personal protective equipment (PPE) they did not check the person's hands were clean which increased the risk of infection.

We observed staff transported used bed linen around the home unbagged. We saw information to suggest the national patient safety colour coded cleaning regime was in place. However, only one colour coded mop was available. Communal bathrooms had mould and mildew around the bath, shower and some floor areas. There was a broken toilet cistern and a worn toilet seat in one communal bathroom which posed a cross infection risk.

People's care needs were assessed and risk assessments were linked to these needs, however, we found these to be basic and brief. The risk assessments described a situation, what could go wrong, the possibility of it happening, action to be taken, by whom and when. However, there was very little information recorded under each heading. We found that none of the people had a risk assessment in place regarding their safety whilst accessing the community, something which all people did daily.

We spoke with the manager about this who told us that people regularly travelled alone on public transport during

the day and at night. However within their risk assessments there was little information about the places they may visit, no information about the route they may take, the time they were expected to arrive home and what staff should do if they did not return to the home. The manager and staff told us they would ring the police if people did not come back at night. This showed that staff would act appropriately in such situations to protect people, but this was not formally addressed or documented within their care records.

We found one person did not have any care plan or risk assessments in place. This person had complex mental health needs which meant they were potentially at risk of harm.

We asked the manager about accident reporting. They showed us an accident book with several pages torn off which indicated accidents had occurred. However the manager could not find the accident forms which corresponded with the stubs. We could therefore not be certain that accidents had been properly investigated and preventative measures were not recorded in order to reduce the future likelihood of people being injured. There was no record of accidents held within people's care records. We noted a few minor accidents were documented within the staff handover book, but these were not followed up with actions taken, so we could not trace what action had been taken by the manager.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

Staff recruitment was not robust and in some staff files we found that the provider was not following their own policy with regards to pre-employment checks. We inspected all of the staff files apart from the manager's, who told us the provider kept their records off site.

There was no evidence to confirm that Disclosure and Barring Service (DBS) checks had been carried out on all employees. An ISA First Check had been carried out for some staff and they had confirmed in writing that they did not have any police cautions or convictions. An ISA check is not a full enhanced DBS check. We were unable to ascertain whether correct pre-employment vetting had been carried out.

One staff file only contained one referee and it was not their previous employer. Other staff files contained two

Is the service safe?

references but again these were not from the applicant's previous employment. We also found gaps in applicants' employment histories which had not been explored or explained anywhere.

We noted that the manager had accepted training certificates for a care worker from a previous employer as proof of awareness in key topics such as medication and safeguarding. These certificates had been issued under a different surname which was not referred to in any of the pre-employment documentation. These observations showed that staff were not safely recruited.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed.

Safeguarding policies and procedures were in place for staff to follow in line with local authority guidance designed to protect people from abuse or improper treatment. Staff were aware of their responsibility to report safeguarding matters; however, we found no records of any safeguarding incidents or low-level concerns within the safeguarding files which were set up.

Staff had documented events which had taken place during their shifts and we found 24 events which related to safeguarding. Most of these incidents involved the police. The manager told us that to their knowledge these incidents had not been reported to the local authority safeguarding team for investigation.

People told us that there was a house rule which stated people had to be in their rooms by 11pm. People were under the impression that it was to ensure nobody had an accident whilst the care worker was sleeping. The manager and staff on duty confirmed this. A person told us "That's the rules; you have to be in your room by 11pm. You can't have a smoke after 11pm because the staff go to bed". Another person said "That's the rules; don't talk about it". The manager informed us that most of the people were not at risk of falls and there was no history of accidents. We found this restriction to people's freedom to be a disproportionate response to a perceived risk.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding people from abuse and improper treatment.

The premises in general were in a good state of repair and decoration. The manager told us "X (the provider) is very

supportive, he comes here a lot. He has done a lot for this home. If I need anything – within reason, I have got no problem at all". However, we observed several issues related to the maintenance of the premises. These were not logged in the maintenance book and the manager contacted the maintenance man during the inspection. The emergency lighting test was overdue and there was no evidence of recent portable appliance testing (PAT) on electrical appliances.

We observed an invoice about an electrical installation test dated 1 December 2009 where an engineer had stated the test found the wiring to be "unsatisfactory". The manager was unable to produce any further documentation related to this matter and was unable to confirm if a five year electrical installation test had been carried out.

There was no information kept about the installation of two stair lifts used by people or the servicing history of this equipment. Legionella testing and a gas safety check had been carried out in February 2015. The fire alarms had been formally tested in August 2015 this was confirmed by Tyne and Wear fire service. There were however no records of practice evacuations or regular fire alarm testing. We passed our concerns regarding fire safety to Tyne and Wear Fire Service fire safety team.

We observed that upon opening a first floor window, the restrictors did not take effect and we were able to push the window wide open. This posed a risk to people as bedroom furniture could easily be climbed upon to access the window. When we asked the manager about this she told us that restrictors on all of the windows in the property could be easily overridden by flicking a catch.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safety of premises.

There was a communal emergency contingency plan in place; this was displayed in the foyer. People had personal emergency evacuation plans kept within their care files.

People told us they felt safe living at the service. Comments included "I feel safe here, I like it, the staff are friendly" and "I know I would go to X (manager) if I needed anything".

Eight people living at the home had some form of support or assistance with medication. We observed medication assistance taking place. Staff were knowledgeable and competent with this task. Medicines were stored

Is the service safe?

appropriately and securely. The manager and staff were knowledgeable about the provider's medication policy and procedure. One person took a particular medicine which required administration by specialised techniques and staff were able to tell us about their needs and how they

supported the person. Another person was diabetic and the manager and staff were able to tell us about their medication and the control measures in place to promote the person's health and well-being.

Is the service effective?

Our findings

There were enough staff employed at the service to meet people's needs. Staff were knowledgeable and had the necessary skills to carry out the tasks required of them. On-going training in key areas was delivered by an external training provider and some staff were working towards a qualification in health and social care. When necessary there were key members of staff who were competent enough to act in a more senior position in the absence of the manager.

There was an induction process in place and a probationary period to ensure staff were suitable for the role. Supervisions were carried out regularly and staff told us they were happy and felt supported by the manager. Comments included, "I love it, I get on well with everyone, it's a nice, homely and relaxed atmosphere. It doesn't feel like coming to work, I'm very happy here; I love my job. I feel appreciated. We got a Christmas present last year. There is plenty of support from X (manager). Anything I need to know, if she doesn't know, she'll find out."

Supervision and appraisal records were maintained and records showed that staff meetings took place monthly. Staff told us they felt supported and could raise issues of concern with the manager at any time.

Regular resident meetings also took place and notes from these meetings were recorded although it was not clear how involved people were in discussions at this meeting, or designing the agenda in advance. People told us they had attended some meetings; one person told us "I haven't been to a meeting; I don't know about them" and another said, "I have never really complained, there are meetings sometimes – I can't tell you how often but they take a record."

All care plans had a section in which to record that people had consented to their care and treatment. Staff all had received training in mental health awareness which covered a variety of conditions and disorders. They were aware of those people who displayed behaviours which can be perceived as challenging and they were able to tell us how they would deal with such behaviour. Staff had a good rapport with all the people living at Melrose House and told us "people are easily talked out of it, if not we let

them go out and we watch from the window that they are just outside, calming down." Records showed that when past incidents had occurred staff had called the police for assistance.

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 it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The manager told us that no-one currently living in Melrose House was subject to a DoLS application. This meant that all people were free to come and go from the home as they wished. Some people had chosen to keep their bedroom door locked and kept their own key.

People's health and well-being was promoted. We saw menus displayed on the walls with a wide variety of food choices for breakfast, lunch and evening meal. Staff told us "If people don't fancy something on the menu, it can be easily changed." People confirmed this and added that they could make sandwiches or have soup if they weren't that hungry and they could make a snack and a drink whenever they wanted one. We observed people making their own sandwiches and cups of tea safely in the kitchen and cleaning up after themselves. One person was helping the staff to prepare jacket potatoes for the evening meal. We heard the member of staff and the person helping offer choices to the other people around the table with regards to a filling for their jacket potato and whether or not they wanted salad on the side. Staff regularly offered people fresh cups of tea or a drink of juice.

We observed in people's care plans that dietary needs had been documented and where considerations had to be made towards controlling food, people's consent was sought to monitor this. For example, were a dietician had made recommendations, the service was supporting the person to achieve their weight loss goals.

Is the service effective?

The service had responded to people's general healthcare needs by contacting external healthcare professionals such as GP's as and when necessary. People were also referred to their CPN or social worker if their mental health needs were changed. There was written evidence that staff had contacted specialists for appointments such as diabetic eye screening, general opticians, podiatry and dentists. One person told us, "They would and have rang a GP for me when I've needed one – like when I had a bad back".

Although we identified in some areas that minor repairs were necessary, the premises was suitably adapted for the people living at the service. The new kitchen extension was full of modern appliances and was well looked after. We

observed people washing their dishes up and cleaning benches after use. There was a rota on the wall which staff and people told us had been agreed at a meeting, to ensure the kitchen was always left clean and tidy for everybody's benefit.

Outside to the rear of the property, there was a courtyard which has several plant pots for people to carry out any gardening activities. There was also a separate smoking hut for people to use. There was a rota on the wall in the 'smokers hut' so the people who used it took their turn to clean up and sweep it out. Stair lifts were in place and there was a walk-in shower with handle supports for those people who required assistance.

Is the service caring?

Our findings

Staff were very friendly and approachable. People told us they really liked the staff. “X (manager) is lovely, friendly and helpful. I like all the staff. They cook my meals, give me medicines for my diabetes, monitor my diet and take my bloods.” In an annual survey, one relative had commented, “We have always found the staff efficient and caring and always kept us informed.”

We observed staff interactions with people throughout the inspection. They were caring, kind and considerate towards people’s needs. We observed one person coming downstairs ready to go out into the community who was wearing odd socks. The staff member took the person to one side and pointed this out, encouraging them to go back upstairs and change their socks. We also heard staff say, “Come on X, we’ll go and dry your hair nice for you going out today.”

We observed some concerns around privacy and dignity. During a tour of the home, we noticed a curtain pole had fallen down from a window with no blinds. This room was habited and could be viewed from the street outside. The manager confirmed that this curtain pole had not been in place for approximately two weeks and that although she had mentioned it to the maintenance man, it had not been fixed. We also noted another person’s room did not have a light shade in place and a pillow was on the bed which did not have a pillow case on it. The manager told us that these matters would be addressed immediately.

Staff understood that people were all individual and encouraged them to be independent, make their own choices and manage tasks themselves wherever possible. The manager told us that they had no-one living at the service who had an obvious diverse need such as a particular religious affiliation or different culture. The manager and staff were aware that people could have different needs like being a vegetarian and they told us this was discussed when they drafted people’s initial care plans. Staff explained that they tried to encourage people to eat a healthy diet and support them to give up smoking, but inevitably these choices were their own to make and they respected that fact.

We observed staff involved people in activities including preparing meals, tidying up and watching movies. They

listened to and cared about what people were telling them during these activities. There were many conversations between staff and people and staff encouraged positive relationships between people. There was a noticeboard in the dining room which had information displayed about local community groups. We noted there was a leaflet about Learning Disability North East. One person spoke very enthusiastically about cooking for ex-soldiers and singing songs. They commented, “I go there by myself on the bus or the metro. Sometimes X (another person) comes with me. I love cooking and the choir.”

One person told us how staff had helped them decorate the home for Halloween. They said, “We dressed up; I was a witch.” The manager confirmed staff had assisted people to bake cakes and that four people had worn fancy dress. They also told us that at Easter they had held an Easter bonnet competition and everyone got involved.

People had been encouraged to complete short courses and gain qualifications. We observed some people’s records included certificates for English and Mathematics qualifications that they had obtained.

Staff told us how they promoted people to be as independent as possible and they encouraged people to develop their confidence by doing things alone. One person confirmed this and said, “I can go out anytime I like; I’ve never had any problems – I’ve been on a train for hundreds of miles before and made my own way back.”

We asked the manager about advocacy. An **advocate** is a person who represents and works with people who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. The manager told us that three people had a formal advocate who acted on their behalf, which had been arranged by their care manager.

All people had control over their financial affairs with support from staff. We observed financial transactions between staff and people. Funds were stored appropriately and securely and people could ask at any time for money from their fund. The transaction was documented and signed by staff. People were encouraged to also sign the transaction; however both of the people we observed declined to do so. We noted this preference was documented in their risk assessment around managing money.

Is the service responsive?

Our findings

We reviewed all eight of the care plans in place for people at the home. Whilst these contained relevant information they were not specifically person centred. All of the care plans had general sections for example, pre-admission assessment, support with personal care, managing medication and managing finances. Not all care plans had a corresponding risk assessment. No consideration had been given to risk assessing people when accessing the community, despite all care plans stating there was a need for such risks to be assessed.

There was section for monthly evaluations and key worker sessions; however these were brief in their content. The monthly evaluations contained basic information about activities, health, finances and outings that had taken place. The key worker sessions recorded a meeting between the person and their keyworker. These records were often just a couple of sentences signed by the staff member but not the person concerned.

Daily diaries for each individual were in place to record any updates, events from that day, appointments, any support required and any issues or concerns that had arisen. These diary entries were brief and repetitive. There was no record of actions taken against any issues that were logged.

We identified one person who did not have a care plan, risk assessment or daily diary in place. This person had complex mental health needs and had been living at the service for six months. Staff and the manager were both

aware that this person did not have these individual care records in place. The member of staff on duty told us, and the manager confirmed that this was because the person was considered to be on a respite placement in the home and they said "We thought 'X' wasn't staying." There were no monthly evaluations for this person, no key worker sessions documented and no daily updates.

The staff handover book contained lots of daily entries about this person. Information was recorded in the staff handover book about their well-being, moods, mental health, appointments and negative interactions which occurred between staff and other people. There was no evidence that any action had been taken following the 'handover' of information and because this person did not have their own individual care plan or risk assessment, these concerns were not documented appropriately in order to regularly review the care and treatment they received.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

Staff ensured that there were a wide variety of activities available such as bingo games, books and jigsaws; although most people told us they preferred to go out into the community. Where one person could not physically access the community, staff had arranged for a day centre placement on a weekly basis, so that this person could be taken out to enjoy social activities and companionship.

Is the service well-led?

Our findings

In the absence of a registered manager, the registered provider has a legal responsibility to notify us of certain incidents as specified in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Our records show that we had not received any notifications since January 2014. During our inspection we found multiple incidents including some which involved the police, and safeguarding matters where notifications had not been made. This evidence demonstrated the provider was in breach of the aforementioned regulation. We are dealing with this matter outside of the inspection process.

The manager told us they carried out regular visual checks around the home related to cleanliness and maintenance, but that there were no formal audit checks recorded. We shared our concerns about cleanliness levels with the manager and they agreed that standards of cleanliness were not acceptable and should have been addressed.

There was a maintenance logbook containing jobs to be actioned by the maintenance man on a regular basis. However, repairs needed around the premises that we had identified, had not been entered into this log. The manager contacted the maintenance man with a list of jobs to be carried out as soon as possible, related to our findings.

The manager confirmed there were no overall service audits done and that although the provider visited the home most weeks, no formal checks or audits were carried out during their visits. The manager told us that more assistance with the management aspects of the service would be appreciated.

Quality monitoring consisted of the manager working through a 'tick-box' checklist. There were no audits in place for the manager or staff to follow and no action plans were created where issues may be identified. Our inspection of care files demonstrated the checklist system was not robust as it did not identify where reviews and changes to care records were needed to ensure information was current. In addition, the shortfalls that we found in respect of staff recruitment processes were not identified via the tick-box checklist. The manager had not realised that one staff member still required a second reference or that the information they had received and documented, did not constitute a full enhanced DBS check.

There was a training matrix in place which recorded when staff were last trained in key topics such as fire safety and infection control. This matrix had highlighted where some staff needed their training to be refreshed, however there was no action plan in place on how this was going to be addressed. We had concerns about the training the manager had sourced and the qualifications of the person delivering this training.

We looked through the daily staff handover book. There were many entries showing that staff had passed information to the oncoming staff team and manager which included comments, concerns and any other matters. However, there were no further notes or an action plan in place to evidence what had been done to address any of the concerns or issues raised by staff.

There was no auditing of accidents and incidents which had occurred. Although the book was available, the pages which contained the information about each individual accident had been torn out and could not be located by the manager.

The manager had carried out an annual survey of the opinions of people, relatives and healthcare professionals. The surveys were available for us to view, however there was no correlation of the results to get an overall picture of people's views and there was no action plan to address any issues which were raised. Comments made included, "Possibly alarm front door to alert staff late at night".

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

There was a relaxed and open culture at Melrose House. People living at the home said they were comfortable and confident enough to approach the staff and manager with any issues or problems they may have. The service had several community links including Learning Disability North East and other local drop-in centres which people visited regularly. There was a 'service user guide' and statement of purpose in the foyer including an easy read guide for some people. This meant people had information available to them about the service and what it could offer them, in a format that met their needs.

Is the service well-led?

The manager had been in post since July 2014. At the time of our inspection they had applied to the Commission to become the registered manager of this service and their application was in progress. The provider is legally required to have a registered manager in post at this service.

We identified concerns with the leadership and management oversight of the service. Governance systems were not effective and did not identify the concerns that we found at this inspection.

The manager said they were trying their best to make Melrose House a nice place to live. The manager could not tell us when any further works were planned by the provider to adapt the premises in the future.

It was evident that people were cared for and people told us they were happy. However, the governance of the service which underpinned all of the fundamental standards was not effective enough to ensure that people received high quality, safe care. The manager agreed with all of our findings, which we feedback at the end of our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met: People who used the service and others were not protected against the risks of receiving unsafe care and treatment as cleanliness and infection control measures were not adequate and personal risks had not been appropriately assessed. Regulation 12(1)(2)(a)(b)(d)(h)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met: People who used the service were not protected because systems to share and investigate safeguarding issues were not operated effectively. Bedtimes were inappropriately restricted. Regulation 13(1)(2)(4)(b)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

How the regulation was not being met: People who used the service and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate safety and maintenance checks. Regulation 15 (1) (c)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: Recruitment procedures were not operated effectively. Regulation 19(1)(2)(a)(3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: Good governance systems and processes were not established. Risks were not assessed, monitored or mitigated.

Records in relation to care delivery, staff and the operation of the service were inadequately maintained.

Regulation 17 (1) (2) (a) (b) (c) (d)

The enforcement action we took:

We will report on the action taken when it is complete.