Leicestershire County Council

Melton Short Breaks Service

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Melton Short Breaks Service is a residential care home providing personal care to autistic people and people with a learning disability, physical disability, sensory Impairment and to younger Adults. Melton Short Breaks service is registered to accommodate up to 6 people at any one time in an adapted building. At the time of our inspection 5 people were staying at the service but they supported 42 people who accessed the service for short breaks at various times throughout the year.

People's experience of using this service and what we found

Right Support: Medicines were not always managed safely and there had been a number of medicine errors. People's records sometimes contained conflicting information about their care needs. Not all staff had up to date training.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: The service was caring. Feedback from relatives was positive. They felt their loved ones were well cared for and enjoyed staying at Melton Short Breaks Service.

Right Culture: There was a lack of leadership within the service. This had allowed a culture of some poor practices to develop and continue. Staff felt they could not challenge leaders, even when they knew best practice was not being followed. Staff reported issues were not dealt with correctly.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 5 October 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

The overall rating for the service has changed from good to requires improvement based on the findings of

this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to the management of medicines, keeping people safe from abuse, staff training, mental capacity assessments and managerial oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Melton Short Breaks Service

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by 2 inspectors. On the first day of inspection 1 inspector visited the service and on the second day of inspection 2 inspectors were present.

Service and service type
Melton Short Breaks Service is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Melton Short Breaks Service is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people there to speak with us.

Inspection activity started on 15 November 2023 and ended on 24 November 2023. We visited the location's service on 15 and 17 November 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed care records for 5 people who regularly stay at Melton Short Breaks Service. We sought the views of 1 person, 3 relatives and 2 health professionals. We spoke with 9 staff including the registered manager and the service improvement manager.

We reviewed a range of records including medicine records, audits, recruitment files, complaints and accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Learning lessons when things go wrong

- Medicines were not always managed safely. Multiple medicine errors had occurred. For example, staff did not always ensure medicines which were being booked in, were competently checked by 2 staff members. This was not in line with the provider's policies and procedures and meant that errors were not identified prior to people receiving their medicines.
- Investigations into medicine errors were not robust and failed to identify all shortfalls. For example, an incident report had been completed because a person missed a dose of epilepsy medication. The records showed the person had missed 2 doses; however, this had not been identified during the investigation, or by the senior staff member who signed the incident off at closure.
- Staff were not competency checked in all areas of medicine administration. Some staff member's competence records had gaps for the application of creams, despite people using the service requiring creams to be applied during their stay.

The provider's failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;

- Risks associated with emergency evacuations were not concisely recorded. For example, records for 1 person stated the sudden noise of a fire alarm could have adverse consequences for them in an emergency. However, there was no information or guidance on the emergency evacuation plan for staff on how to support the person and mitigate the risks posed to them.
- People's care and support records sometimes contained conflicting information. For example, 1 person's records stated they required turning regularly. However, it was not clear how frequently they required turning as the length of time in between the turns differed in the person's care records.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse and improper treatment. We identified one restriction which had been imposed on a person and this negatively impacted them.
- Staff we spoke to told us they knew how to raise a safeguarding concern, and all staff had received safeguarding training. However, there was no evidence staff had identified the restriction described above prior to the inspection.

Staff were not aware of their responsibilities to prevent, identify and report abuse. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There was a shortage of permanent staff to cover shifts, and the service relied on agency staff to ensure there were sufficient numbers of staff to meet people's needs. The provider had tried hard to recruit, however, given the location, had found this a significant challenge.

● The provider had recruitment policies and procedures in place at provider level, however, these were not always followed. The provider told us that some recruitment documents were kept with the head office team, whilst other documents were kept locally. This meant the provider had some difficulty in collating all of the information for each staff member when we needed to look at recruitment files.

● Staff were missing interview records, which was not in line with the provider's policy. Some staff were also missing background information such as employment history, and health declarations. This meant the provider was unable to evidence they were meeting legal recruitment checks.

Preventing and controlling infection

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

Visitors were welcomed into the service with their loved ones. There was no restriction on friends and relatives spending time with people, and there was a variety of places for people to sit with visitors.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always have sufficient training to be able to meet people's needs. For example, a number of staff did not have evidence of moving and handling training. Some people who stayed at the service require staff to support with moving and handling and this meant there were not always suitably trained staff on duty. Another staff member was found to have significant amounts of out of date training.
- Programmes of supervised medication sessions to improve staff knowledge were not always seen through to completion. For example, 3 supervised medication sessions were planned with a staff member where concerns had been identified. However, there was only evidence that 1 session had occurred. This meant the provider could not be assured the staff member had improved their professional skills, necessary for the safety of people. The provider told us they were completing regular supervisions with staff members.

The provider's failure to ensure staff received sufficient training and support was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not working in line with the Mental Capacity Act 2005 and the associated codes of practice. Five people's care records were reviewed in respect of mental capacity assessments, and concerns

were found with all.
● A person's file contained conflicting information regarding their mental capacity. This meant it was difficult for staff to ensure they had consent before providing the appropriate level of support to the person.
● Where people were deemed to lack mental capacity, best interest decisions had not consistently been completed. For example, 1 person was deemed to lack mental capacity in all areas of their life and had numerous mental capacity assessments in place. However, only 2 best interest decisions had been completed. This meant staff did not have sufficient guidance to ensure the care and support they delivered to the person was in their best interests.

The provider failed to clearly record people's mental capacity, and to ensure that relevant best interest decisions were completed. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acknowledged these concerns and produced an action plan to describe the actions they would take.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care and support was not always delivered in line with guidance. For example, the provider had been issued with guidance for a person who stayed at the service. This guidance stated the person could often describe physical pain, as a result of feeling emotionally unsettled. An incident occurred where the person did express physical pain to staff, however, staff administered pain relief, rather than following the guidance document to understand if this was a genuine physical pain, or a way of them communicating emotional upset.
● People did receive referrals to health professionals when needed. Given the nature of the service, this was not frequently required, however, during the inspection we noted a referral had been made and the provider was awaiting the outcome.

Adapting service, design, decoration to meet people's needs
● Melton Short Breaks Service is a purpose-built building which has been thoughtfully designed for the people who use the service. All bedrooms had large ensuites wet rooms, which contained both an accessible shower and a specialist bath. Corridors and doorways were wide enough to accommodate wheelchair users.
● The environment was exceptionally clean and tidy. Bedrooms were tastefully decorated in colour themes, given that they could not be specially personalised for people given the nature of the service.
● There were a variety of large communal spaces, which offered people space to come together, or have time alone. The service had a purpose-built sensory room which was accessible for everyone, and a safe, accessible garden for people to enjoy.

Supporting people to eat and drink enough to maintain a balanced diet
● People had plenty of food and drinks provided to them during their stay. Staff understood people's dietary requirements, and preferences. A well stocked fruit bowl was available to people to access at all times.
● People were encouraged and supported to cook and bake during their stay. This increased people's confidence and knowledge with cooking and preparing meals. The service had 2 kitchens which replicated household kitchens to provide a realistic environment for people.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated with kindness by staff who delivered care.
- Relatives were complimentary of the staff team. One relative said, "They treat [person] with such importance."

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People's dignity and independence were respected. We found one example of language used on a form that could have been perceived as derogatory. This was raised with the provider who took immediate action to rectify this.
- Relatives felt people were supported to be independent where appropriate. A relative said the service had asked them how the person could be supported with improving their independence.
- There was some evidence people were involved in discussions about their care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- There were shortfalls in how people's needs were identified, particularly in respect of protected equality characteristics. For example, sexuality care plans were not in place. This meant staff did not have information on how people preferred to identify, dress, or their sexual orientation, to enable them to support people in a person-centred way.
- People's religious needs were not well-documented. For example, 1 person liked to pray multiple times a day. There was no religious care plan in place, and there was not robust information in their care records. This meant staff did not have guidance on how they were able to support the person to meet their religious needs, such as the times the person liked to pray, any equipment they may need to facilitate this, or any personal care needs which may need to be met prior to the person praying.

These concerns were raised with the provider, who produced an action plan describing the actions they had taken immediately to rectify this, and the actions they would continue to take to prevent reoccurrence.

Improving care quality in response to complaints or concerns

- The provider did not always improve the quality of care when complaints or concerns were raised. The provider had received some complaints which had recurring themes. For example, a relative had complained and stated that a personal item had not been returned at the end of their stay. During telephone feedback with relatives as part of the inspection, another relative advised that sometimes their loved one's personal effects were not returned. This meant the actions the provider had taken in response to the first complaint were not effective.
- Concerns from staff were not always acted upon. For example, daily care records did not always contain accurate logs of people's care, and staff had advised that some agency staff handwriting was illegible. This had been raised in 2 team meetings prior to the inspection, however, we identified these concerns to still be present at the inspection. This meant learning was not applied to practices within the service when concerns were raised. Following the inspection, the provider provided assurances on the actions they would take to improve this area.
- People and relatives knew how to make a complaint.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in

relation to communication.

● People had communication passports in their files which explained how they preferred to communicate with staff and others staying at the service.
● The service had created easy read staff profiles with photos so people could see what staff members looked like, if they supported them in the day or at night, and brief description of activities staff liked to participate in.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People experienced a wide and varied programme of opportunities in regard to how they chose to spend their time. The service kept scrap books which showed activities people had participated in. Some of these included days out to the Sealife centre and a local bird sanctuary, a trip to the seaside, going out to eat at different places, and theme parks and funfairs.
● People were supported to engage in ways that were socially and culturally relevant to them, such as Diwali celebrations, a trip to a local church, activities to celebrate the King's coronation and a day out at the Pride festival.
● Within the service, there was plenty for people to do. A large cupboard was filled with games and activities, multiple TV's across the service to allow people to watch different shows or films, a pool table, and a karaoke machine which the registered manager advised was a firm favourite for people who stayed at the service.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to operate effective quality assurance systems to assess and monitor the safety and quality of people's care. Audits were not robust and failed to adequately identify and address shortfalls in the safety of the service, including, but not limited to, medicines management, care planning and risk management, staff training and mental capacity assessments.
- Systems to ensure accurate records and equipment was in place in the event of an emergency were not effective. For example, ski sheets which should have been attached to mattresses to enable a swift evacuation to take place, were not correctly fitted. This rendered them ineffective. This was raised with the provider who took immediate action to rectify this.

The failure to ensure systems and processes effectively assessed and monitored, and learning was shared, was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed an action plan. The provider acknowledged the majority of our findings and provided information and assurances on the actions they had taken immediately to rectify issues, and the actions they would continue to take to improve the safety and quality of the service provided.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of leadership within the service. The provider and registered manager were unaware of all the issues within the service. This had allowed a culture of some poor practices to develop and continue.
- Staff told us confidentiality was an issue, as it was not adhered to and there had been instances when confidential information had been overheard and shared by senior staff members.
- Staff felt they could not challenge the way leaders did things, even when staff knew things were wrong. Staff reported issues were brushed under the carpet and not dealt with correctly.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager told us they were aware of their role in relation to the duty of candour, however, this differed to feedback from staff. Notifications had been submitted when required.

Working in partnership with others

- The provider worked in partnership with others where appropriate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to clearly record people's mental capacity, and to ensure that relevant best interest decisions were completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failured to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff were not aware of their responsibilities to prevent, identify and report abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received sufficient training and support.