M Rashid

Melrose House

Inspection report

Melrose House
95 Alexandra Road
Southend On Sea
Essex
SS1 1HD

Tel: 01702340682
Website: www.melrosehouse.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Melrose House provides accommodation, personal care and nursing care for up to 34 older people and older people living with dementia.

The inspection was completed on 29 March 2016 and 31 March 2016. There were 32 people living at the service when we inspected.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the Care Quality Commission. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

A registered manager was in post. 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.

There was a lack of provider and managerial oversight of the service as a whole. Quality assurance checks and audits carried out by the registered manager were not robust, did not identify the issues we identified during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered. Controls to manage the risk from hot water were not in place and therefore increased a scalding risk to people using the service. Safety checks relating to the service's gas and electrical installations had not been completed at suitable intervals to ensure that these were safe. Individual Personal Emergency Evacuation Plans (PEEP) were not in place to respond effectively to health and safety incidents and other emergencies that may

occur. Equipment within the kitchen and adjoining utility area were not properly maintained and people did not always have access to an appropriate supply of hot water.

People did not think that there were sufficient numbers of staff available to meet their needs or their relative's needs. The deployment of staff was not appropriate to meet the needs of people who used the service and required reviewing so as to ensure people's care and support needs were met. Staff did not have time to spend with the people they supported to meet their needs and the majority of interactions by staff were routine and task orientated. Suitable arrangements were not in place to ensure that the right staff were employed at the service.

The implementation of staff training was not as effective as it should be so as to ensure that staff knew how to apply their training and provide safe and effective care to the people they supported. Not all staff had received regular supervision or an annual appraisal. Formal support arrangements were not always in place for staff and people did not benefit from a well-supported staff team through appropriate training and supervision.

People did not always receive care that was responsive to their needs or care that was carried out in a person centred way. This was because staff shortages and poor deployment of staff at times meant that staff's approach was often task focused and routine based.

While formal arrangements were available to assess the needs of people prior to admission, these had not always been conducted by the service, particularly for people admitted to the service on respite from hospital. Not all of a person's care and support needs were identified and documented. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Significant improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability.

Although there was a complaints system in place, management arrangements to investigate complaints thoroughly and to evidence outcomes were inconsistent and the provider's policy and procedures had not been followed.

Staff were able to demonstrate an understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Arrangements for medicines management at the service were safe and ensured that people received their medication as they should.

Despite variable comments from people about the quality of meals provided, the dining experience for people was positive and people had their nutrition and hydration needs met. Appropriate assessments had been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected.

You can see what actions we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Steps were not in place to ensure that the deployment of staff was appropriate to support people safely.

Effective recruitment procedures were not in place to safeguard people using the service.

The management of medicines ensured that people received their prescribed medication.

Is the service effective?

Inadequate

The service was not effective.

There was a lack of evidence to show that staff had received a thorough induction or received regular formal supervision or an appraisal.

Although there were variable comments from people about the quality of meals provided, the dining experience for people was positive and people had their nutrition and hydration needs met.

Appropriate assessments had been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although some people stated that staff treated them with care and kindness, care provided was often task focused and people said that staff did not sit and talk with them for any meaningful period of time. Staff communication with some people was poor.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

People were not engaged in meaningful activities or supported to pursue pastimes that interested them.

Effective arrangements were not in place for the management of complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight of the service as a whole.

People were put at risk because systems for monitoring quality were not effective. The systems had also not identified the areas of concern that we had found.
The culture of the service was not centred on the person but was more around the tasks that the staff had to achieve each day. This approach did not support people's individual needs.

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 29 March 2016 and 31 March 2016 and was unannounced. The inspection team consisted of two inspectors on 29 March 16 and 31 March 2016. On 29 March 2016 the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

Before our inspection we reviewed the Provider's Information Report (PIR). This is information we have asked the provider to send us to evidence how they are meeting our regulatory requirements. We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and registered manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 people who used the service, seven relatives, nine members of care staff, the chef and kitchen assistant and the registered manager.

We reviewed 12 people's care plans and care records. We looked at the service's staff support records for six members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, this was inconsistently applied. Additionally where risks had been identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

For example, one person had redness and a moisture lesion on their body. No formal assessment had been put in place to provide an estimated risk score for the development of pressure ulcers. A risk assessment had not been completed to ensure that suitable control measures were put in place to mitigate the risks or prevent further deterioration relating to the management of pressure ulcers. Where people had a catheter fitted, no risk assessment was in place to reduce the risks of potential risk of harm to the person, such as, the development of urinary tract infections, bladder spasms and leakage around the catheter site which could be a sign that the catheter is blocked.

Our observations on 31 March 2016 showed that three people were assessed as at risk of developing pressure ulcers. We checked the setting of their pressure relieving mattress. We found that it was not possible to determine if the equipment was correctly set in relation to the person's weight as two out of three people had not been weighed for the period January 2016 to March 2016 inclusive. This meant that we could not be assured that the amount of support the person received through their pressure relieving mattress was correct and would aid the prevention of pressure ulcers developing or deteriorating further. Staff told us that they had raised this with the registered manager but that nothing had been done.

Prior to our inspection, concerns were raised by the Local Authority in relation to the high incidence of falls at the service. On the 31 March 2016 the registered manager confirmed that an accident matrix form had been newly implemented at the service. This showed that between 31 December 2015 and 15 March 2016 there had been approximately 18 incidents whereby a person had experienced a fall, lost their balance or rolled out of bed. However, there was a lack of correlation between the list of accidents recorded, actual incident reports, information recorded within individual people's daily care records and the service's diary for 2016. There was no evidence that sufficient information was recorded to enable the service to identify fall patterns and trends, such as, particular times of the day, particular activities or consideration of 'near misses' that could have resulted in a fall or injury. No information was recorded as to the outcome and the use of external influences, for example, communication with the local falls team or other healthcare professionals. This showed that the accident matrix was ineffective as the information recorded was not up-to-date, accurate or properly analysed so as to understand the significance of the information. Furthermore, it showed that the above was not being monitored so as to improve the quality and safety of people and ensure that appropriate action was taken. Actions highlighted from a Local Authority strategy meeting in January 2016 in relation to falls management had not been addressed. This related specifically to the implementation of a robust falls recording procedure and falls training for staff.

Reasonable steps to ensure the health and safety of people using the service and others were not always

considered. On 31 March 2016 the hot water temperatures from wash hand basins varied from as little as 18° degrees centigrade to over 50° degrees centigrade within people's rooms and communal toilets. The registered manager confirmed that Thermostatic Mixing Valves (TMVs) were in place to ensure that water hotter than 44° degrees centigrade was not discharged from outlets. However, the registered provider and registered manager were not following their own procedures for checking hot water temperatures at the service and ensuring that these remained at a safe level for people's safety and wellbeing. Regular safety testing to ensure that the TMVs fitted remained safe and effective had not been carried out. This meant that controls to manage the risk from hot water were not in place and therefore increased a scalding risk to people using the service. As part of our inspection process we requested urgent action from the provider in regards to the excessive temperatures following our visit and they confirmed shortly after that the affected TMVs had been inspected and repaired.

On 31 March 2016 one person was observed to be in the rear garden of the premises. The person was alone and without staff support. We were talking with a member of staff in lounge three and upon seeing the person outside the member of staff attempted to open the fire exit door but was unable to open it. We attempted to provide assistance but found the fire exit door in lounge three was bolted and clearly could not be opened in an emergency. This meant that in the event of a fire, people and others would not be able to escape to a place of safety, for example, the garden. We wrote to the registered provider on 1 April 2016 and requested that they take immediate action to address the issue identified. The registered manager confirmed on 6 April 2016 that the works to the fire exit door had been carried out and completed.

Safety checks relating to the service's gas and electrical installations had not been completed at suitable intervals to ensure that these were safe. The electricity at work regulations 1989 require providers to maintain electrical systems and equipment in safe working order. The regulation recommends that the service's fixed electrical installation should be inspected at least once every five years. Records available showed that this was last undertaken at Melrose House on 13 June 2012. The overall assessment of the installation in terms of its suitability for continued use was considered 'Unsatisfactory.' There was no evidence to show that these works had been carried out and the registered manager was unable to tell us if the remedial works and recommendations had been undertaken or not. The gas safety (installation and use) regulations 1998 require providers to make sure gas appliances and fittings are safe. It also requires providers to ensure that an annual gas safety check is carried out. No record was available to show that this had been completed since 8 May 2013. This showed that the registered provider was not meeting the requirements of relevant legislation so that the premises and equipment were properly maintained and were not placing people at risk of harm or potential harm. We wrote to the registered provider on 1 April 2016 and requested that they take immediate action to address the issue identified. The registered manager confirmed on 6 April 2016 that a gas engineer had been in attendance and that a gas certificate would be issued as a matter of priority. They also confirmed that an electrical inspection had been arranged.

Although there was a list of people who used the service recorded within the service's fire risk assessment folder, individual Personal Emergency Evacuation Plans (PEEP) were not in place to respond effectively to untoward incidents and other emergencies that may occur at the service. Information did not state the specific emergency assistance a person required, any precautions that needed to be considered and the equipment required.

Dorguard fire door retainers were in place. These fittings enable fire doors to be legally and safely kept open and allow the doors to close when the fire alarm sounds, therefore preventing the spread of fire and smoke. Fire dorguard checks for the period 3 September 2014 to 23 March 2016 showed that not all fire doors closed automatically and that this remained outstanding and had not been addressed. The checklist recorded that this was on the list for the handyman to repair. For example, lounge 2 had had a fault for the last 22 weeks.

Room 11 was awaiting repair from19 December 2015 to 23 March 2016 inclusive and room 12 was reported as requiring a repair on 6 January 2016, and this still remained outstanding on 23 March 2016. This showed that the registered provider was not ensuring that the premises and equipment were properly maintained and therefore was placing people at risk of potential harm.

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

Comments about staffing levels from people using the service and those acting on their behalf were predominantly negative. People did not think that there were sufficient numbers of staff available to meet their needs or their relative's needs. One person told us, "The night staff are very good, but the day staff are simply too busy, there's not enough of them." The person explained that, on the morning of our first day of inspection, they had used their call alarm to summon staff assistance as they required support with their personal care needs. The person told us that no staff came and so they attended to their own personal care needs. They told us, "I was shaking; I'm still shaking. Nobody came to help me." Another person told us, "I had to wait 45 minutes this morning for staff to answer my buzzer. Another resident was shouting out this morning and I think the staff were attending to them. There's not enough staff on to help us." Another person told us that there were times when they had to wait for up to an hour for personal care and support to be provided. Two relatives from the same family told us that, in their opinion, there were not enough staff available to ensure people's safety. The relatives were concerned that their member of family had experienced several falls which, in the relatives' view, was attributed to insufficient staff being on duty.

Five members of staff and the registered manager confirmed that staffing levels as told to us had not always been maintained. Staff confirmed and our observations showed that staff did not have time to sit and talk with people living at the service, people received little or no social stimulation and people often had to wait for long periods of time for care and support to be provided. For example, staff confirmed that on Sunday 27 March 2016, the last person to be assisted with personal care and got up was at 11.45 a.m. Additionally, two people did not have their breakfast until 11.00 a.m. and only one and a half hours prior to the lunchtime meal being served. One member of staff stated, "There is never enough staff to meet the residents' needs." Our observations on both days of inspection showed that staff did not always have enough time to spend with people to meet their needs.

The deployment of staff was not always suitable to meet people's needs. For example, on the first day of inspection we noted that communal lounge one was left without staff support for a continuous period of 20 minutes and 35 minutes respectively. On the second day of inspection communal lounge two was left without staff support for a continuous period of 40 minutes. Although eight people were seated within communal lounge two, one person had been assessed as 'moderate risk' of falls and required close observation. During this time they made several attempts to stand without staff in attendance and were repeatedly told by others living at the service to sit down. People did not have access to a call alarm facility so as to summon staff assistance or to alert them if there was a problem or an emergency. The care and support provided was routine and task orientated. Staff engagement with people using the service was primarily centred around providing people with a drink, transferring people from their wheelchair to a comfortable chair or vice versa and assisting people to the dining room or to the toilet for personal care.

Staff rosters for the period 1 March 2016 to 31 March 2016 inclusive were viewed. These showed that staffing levels as told to us by the registered manager were not always maintained and there were not always sufficient numbers of staff rostered to provide care and support. For example, the staff 'signing-in' sheet for Friday 25 March 2016, Saturday 26 March 2016 and Sunday 27 March 2016 confirmed what people using the service and staff had told us and evidenced that there were insufficient staff on duty throughout the day and

on two out of three nights. Additionally, the staff rosters were not accurate and had not been amended in a timely manner to reflect where staff had telephoned in sick and did not always include agency staff utilised. The registered manager confirmed that they regularly covered staffing shortfalls; however this was not identified within the staff roster.

The registered manager was unable to confirm how staffing levels at the service were calculated so as to determine the number of staff required. The registered manager confirmed that, although the dependency levels for each person were assessed and recorded each month, there was no systematic approach to analyse the results so as to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances. Therefore it was not always possible to determine if staffing levels were appropriate. However, taking into account the discrepancies within the staffing rosters, our observations, staff, relative's and people's voice we judged the service to be lacking sufficient staff to effectively deploy resources to support people safely and to meet their individual needs and preferences.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable arrangements were not in place to ensure that the right staff were employed at the service. Staff recruitment records for staff appointed within the last 12 months showed that the registered provider and registered manager had not operated a thorough recruitment procedure in line with their policy and procedure. Records showed that not all staff employed had had the appropriate checks to ensure that they were suitable to work with vulnerable people. Despite having an employment checklist in place at the front of each staff member's recruitment file, not all records as required by regulation had been sought or received prior to the commencement of their employment.

We found that satisfactory evidence of conduct in their previous employment, in the form of references, had not been received for three members of staff. There was no evidence that a Disclosure and Barring Service (DBS) certificate had been applied for or received for two members of staff, prior to their employment at this service. There was no evidence to show that an Adult First Check had been obtained or received for either person. This is a check where a person is permitted to start employment with adults before a DBS certificate is in place. In addition, no profiles had been requested or sought for agency staff who worked at the service during our inspection.

The registered manager had not sought clarification from the external agency that staff working at the service had been subject to the same level of checks and similar selection criteria as staff recruited directly. This showed that the registered manager and provider had failed to operate an effective recruitment procedure and we could not be assured that people living at the service were protected by the registered provider's recruitment procedures.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff were able to demonstrate an understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected, the staff training matrix provided by the registered manager at the time of the inspection showed that nearly half of staff employed at the service had not completed safeguarding training. Staff confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if required. Staff confirmed they would do this without hesitation in order to promote people's safety and wellbeing.

People told us that they received their medication as they should and at the times they needed them. The arrangements for the management of medicines were safe. Medicines were stored safely for the protection of people who used the service. There were arrangements in place to record when medicines such as tablets and liquid medication were received into the service, given to people and disposed of. We looked at the records for 10 of the 32 people who used the service. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. Observation of the medication round showed this was completed with due regard to people's dignity and personal choice.

The registered manager confirmed that in addition to themselves, six members of staff were deemed competent to administer medication to people who used the service. Evidence of up-to-date medication training was only available for four out of six members of staff. Although the registered manager confirmed that staff had been visually assessed as to their continued competency to administer medication, a written record had not been completed or maintained to evidence this.

Inadequate

Is the service effective?

Our findings

Equipment within the kitchen and adjoining utility area were not properly maintained. This referred specifically to the range cooker only having two out of a possible eight burners in full working order. Additionally, only one out of two ovens was fully operational. We initially discussed this with the chef and they advised that the cooker had not been fully operational since October 2015. This was confirmed by the registered manager. We were also advised by the chef and this was confirmed by the registered manager, that the large extractor fan in the kitchen and the 'fly zapper' used to kill flying pests was also not operational. This meant that the service's chef was unable to prepare a range of appropriate meals for people living at the service and timely action had not been taken by the registered provider to address the issues raised.

On 29 March 2016, there was no hot water from the hot water taps in nine people's rooms. In addition, there was no hot water emitting from the hot water taps (wash hand basins in the communal toilets and bathrooms) on the ground, first and second floors. The registered manager and staff told us that this had been highlighted on several occasions; however effective steps had not been taken by the registered provider to remedy the problem in the long-term. We also found that there was no hot water from the hot water taps in the kitchen and adjoining utility area. Records showed that no hot water had been available from Saturday 26 March 2016 to Tuesday 29 March 2016 inclusive. A risk assessment completed by the registered manager on 25 March 2016 confirmed that there was no hot water in the kitchen and some people's rooms and control measures instructed staff to boil the kettle for hot water in the kitchen and to acquire hot water from other people's bedrooms. We discussed this with the registered manager and they advised that both the registered provider and external consultant had been made aware of the issues. It was not until we discussed it further with the registered manager at the time of the inspection that steps were taken to source a boiler engineer.

When we arrived to complete our inspection on 31 March 2016, initially we were advised by the registered manager and chef that the kitchen, adjoining utility area and people's bedrooms had acquired a supply of hot water. However, at 10.00 a.m. the chef confirmed to the registered manager that once again there was no hot water available. Hot water was not available throughout the day and staff confirmed that they were having to source hot water from another person's bedroom so as to wash people. We wrote to the registered provider on 1 April 2016 and requested that they take immediate action to address the issue identified. The registered manager confirmed on Tuesday 5 April 2016 that there was still an inadequate supply of hot water available within the kitchen, adjoining utility area and some people's bedrooms; however a 30 litre urn had been purchased to provide hot water for use by kitchen staff and particularly as the dishwasher had not been operational since 31 March 2016. An email was received from the registered manager 13 days after the inspection, confirming that hot water had been restored to affected areas of the service.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not complimentary about the quality of the training provided. One member of staff told us, "The

training provided at the home is not very good. There is no dedicated time for training as staff are taken off the floor when they should be working. The training is rushed and staffing levels are not maintained." Another member of staff told us, "We do not get regular up-dated and refresher training. The training here does not always cover what we [staff] need." Staff also told us that they did not receive regular training opportunities in a range of subjects. Staff did not feel that the training they received provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs to an appropriate standard.

The registered manager provided us with a copy of the staff training matrix which they confirmed at the time of the inspection was up-to-date. However, following the inspection and on further review, we found that the information contained within the document was not accurate or up-to-date as it did not include all staff employed at the service. For example, we found that out of a total of 26 members of staff employed at the service, 16 members of staff were not included on the training matrix. This had also been highlighted at the time of Southend Borough Council's quality monitoring visit to the service on 19 February 2016. The training matrix recorded the training completed by staff between 2009 and 2015. It demonstrated that updates had not always been provided to staff within this time period.

The provider's Provider Information Return (PIR) also confirmed that there were significant gaps in staff's training. For example, the PIR recorded that only three members of staff had received food hygiene training, these did not include the chefs, kitchen assistants and care staff directly handling food and/or assisted people to eat and drink, which meant they potentially did not have up to date knowledge of safe food handling and hygiene practices to ensure people were protected from the risk of infections or contaminated food.

The staff roster showed that the newly appointed part-time chef commenced employment at the service in March 2016. Records confirmed that they had previous and current experience in catering and had attained Health and Hygiene Level 1 and 2 National Vocation Qualification in 2001. However, there was no evidence to show that this had been updated since 2001 or that their qualification was in line with the National Careers Service advice for their role. A copy of the staff member's qualifications had not been retained or seen by the registered manager at the time of our inspection so as to assure them that the member of staff was suitably qualified.

Gaps in staff's training and our observations showed that people's needs were not consistently met by a staff team who had the right competencies, knowledge and skills to meet people's diverse care and support needs. Where we observed poor staff practice in relation to moving and handling, we found that records were not available to demonstrate that all staff members involved had received manual handling training. On the first day of our inspection we observed on two separate occasions, two members of staff assisting a person to move in a way that was unsafe and put them at risk of harm. Staff were observed to transfer the person from their wheelchair to a comfortable chair in the communal lounge by placing their arms under the person's armpits and pulling the person up. One person was seen to wince and both looked uncomfortable whilst the manual handling procedure was being carried out. No records were available to show that two members of staff had up-to-date manual handling training. One member of staff confirmed that the registered manager had completed practical manual handling training with them but that it had only lasted 20 minutes. We asked to see the registered manager's 'train the trainer' manual handling certificate on 29 March 2016 and 31 March 2016, however this was not made available.

Staff told us they received an 'orientation' induction when newly employed at the service. However, there was no evidence to show that staff had received a comprehensive induction that provided them with the skills and training to undertake their role. Although the registered manager was aware of the new Skills for

Care 'Care Certificate' and how this should be applied, no-one had completed this or an equivalent. The registered manager advised that they did not have the time to assist staff through this process. This meant that we could not be assured that all staff had received a thorough induction that provided them with the skills and confidence to carry out their role and responsibilities effectively.

Staff told us that they did not feel supported and valued by members of the management team or the organisation. The provider's supervision policy recorded, "All care staff should have at least one formal supervision session of at least one hour duration every two months." Although records showed that staff received supervision, the registered manager confirmed that the above frequency had not happened. Supervision records were of poor quality as they did not show the actions agreed or provide confirmation that actions highlighted during the supervision session or previous supervision had been reviewed and addressed. The PIR and registered manager confirmed no staff had received an annual appraisal of their overall performance for the last 12 months. The rationale provided by the registered manager was that they did not have the time to undertake these. This showed that formal support arrangements were not in place for staff and meant that people did not benefit from a staff team who were well-supported through appropriate training, supervision and assessment of their continued competence.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments about the quality of the meals provided were variable. Two people told us, "I think the food is nice here" and, "The food is OK." This was in contrast to another two people who told us, "The food is awful" and, "The food isn't very good here."

We found that the dining experience for people was satisfactory and people were supported to eat and drink. People were supported to use suitable aids to eat and drink as independently as possible, for example, to eat their meal using a spoon and use of specialist beakers. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and positive encouragement to eat and drink was provided. However, some staff failed to provide sufficient information, explanation or reminder to people about the actual meals provided, for example, people were not told what food items were on their plate. People were not supported to wash their hands or offered wipes so as to ensure that their hands were clean prior to eating.

Although people and those acting on their behalf told us that their healthcare needs were generally well managed, we found that some people's healthcare needs, particularly in relation to falls management, were not recorded as well as they should be and improvements were required.

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. 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.

The majority of staff told us that they had not received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff were able to demonstrate a basic understanding of MCA but did not have an awareness or understanding of DoLS and how this related to people living at Melrose House.

Records showed that where appropriate people who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had been recorded. Appropriate Deprivation of Liberty applications had been made to the Local Authority for their consideration and authorisation by the registered manager.

Requires Improvement

Is the service caring?

Our findings

Overall people and their relatives told us that staff cared for people in a caring and kindly way. One person told us, "There are friendly staff here." Another person told us, "The staff are nice and I'm quite happy with the care I receive." One relative told us, "In terms of care, I think it's very good here." However, our findings in terms of how staff were supported to ensure people's well-being and support functions including care records and management support did not concur with people's comments about a caring service. The service needed to improve the way they delivered personalised care to people so as to ensure it was tailored to the individual. This was hindered by the provider's existing staffing levels, poor deployment of staff and lack of effective direction for staff to follow.

Although staff knew the people they supported, their care needs and the things that were important to them in their lives, staff interactions with people were variable. We noted that the majority of interactions were routine and task focused, for example, some staff only spoke with people or interacted with them when providing personal care, assisting them to eat and drink or when providing assistance with manual handling. Our observations showed that not all staff displayed concern for people's wellbeing in a caring and meaningful way or responded to people's individual needs quickly enough. For example, during the first day of inspection, one person requested support with their personal care needs. This was not provided in a timely way as they required two members of staff to support them and only one member of staff was available. When another member of staff became available, support was not able to be provided as another person who used the service became anxious and distressed. Staff were noted to deal with the person's anxious and distressed behaviours but found the overall emerging situation frustrating and stressful as they could not provide timely support to the person who required assistance with their personal care needs. The person had their personal care needs met after 20 minutes. One member of staff was overheard to state to their colleague, "This is just not good enough, we are not meeting people's needs. How can we do this?"

Staff's communication with people living at the service was variable. Some staff, for example, were seen to kneel down beside the person to talk to them or to sit next to them and staff provided clear explanations to people about the care and support to be provided in an appropriate way. Other members of staff were observed to have difficulty communicating with people and understanding their needs, such as not enabling people to make choices or providing clear explanations to a person prior to undertaking a specific task. Where interactions were positive, staff rapport with people living at the service was observed to be friendly and cheerful. This was clearly enjoyed by people and there was positive chit-chat between both parties.

The majority of people told us that they were treated with respect and dignity. Our observations showed that staff respected people's privacy and dignity, such as, we saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to wear clothes they liked and that suited their individual needs.

The registered manager told us that where some people did not have family or friends to support them, arrangements could be made for them to receive support from a local advocacy service. People were supported to maintain contact with family and friends and relatives told us that they were always welcomed

and that there were no restrictions on visiting times.

Inadequate

Is the service responsive?

Our findings

Our inspection highlighted that people did not always receive care that was responsive to their needs or care that was carried out in a person centred way. As already highlighted within the main text of this report, this was because staff shortages at times meant that staff's approach was primarily task focused and routine based rather than person-centred.

People's needs were not given due consideration to ensure their personal hygiene requirements and comfort preferences could be met. There was an on-going lack of hot water available to staff in the service which the provider had not corrected. This meant that staff were unable to respond to people in timely way to support people to wash and maintain reasonable standards of personal hygiene. Two people told us that they had not been shaved for a number of days. One person stated, "There's been no hot water so we've not had a shave." The above showed that the provider was not responsive to meet people's basic care and support needs as people were left without appropriate access to washing facilities and placed undue strain on staff.

Although formal arrangements were available to assess the needs of people prior to admission, evidence showed that these had not always been conducted by the service, particularly for people admitted to the service on respite. Whilst initial assessments provided by the local NHS hospital had been completed, three people admitted on respite had not been assessed by the service. We discussed this with the registered manager and they confirmed that several admissions to the service had been agreed by the external consultant and they had been advised by them that a pre-admission assessment was not necessary or required. This meant that the registered provider did not have suitable arrangements in place so as to assure themselves that the service was able to meet the needs of those people supported on respite care or via short notice admissions. Where assessments had taken place, limited evidence was available to show that where appropriate, this had been conducted with the person or those acting on their behalf and how alternative ways were sought to gain those people's views that were unable to communicate effectively because of their high level of needs. Therefore the provider could not be assured in all cases that they had all the information they needed to provide person centred.

We found inconsistencies across the service in the quality of the information included in people's care records. Not all people's care and support needs were identified, documented or consistently reflected all of their current care needs. During the inspection we were advised that two people required their meals to be pureed as they were at nutritional risk and at risk of choking. Whilst one care plan was in place for one person and made reference to them having a physiological difficulty with textures and lumps in their food, no care plan was evident for the other person. We discussed this with the registered manager. The registered manager checked the care file and found that no care plan was in place. No rationale was provided for this. No manual handling assessment had been completed for two people detailing their moving and handling needs, including the person's ability to support their own weight and the extent to which they could participate with transfers. Both people required the use of a hoist and two members of staff to support them safely. This meant that for these people, their care plans did not fully reflect their care requirements and the support to be provided and delivered by staff to ensure their care needs were met.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had the information required to provide appropriate care. Although specific incidents had been recorded where people had become anxious and distressed, little quantitative information was recorded detailing staff's interventions and outcomes. Therefore we could not be assured that the person was receiving the appropriate support in regards to their anxieties and distress to ensure their wellbeing and others safety.

Significant improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and according to their abilities. People's comments about social activities provided at the service were predominately negative. One person told us, "Nothing happens here. All you do is sit in front of the television. You're lucky if a member of staff talks to you." Another person told us, "There's no stimulation – nothing to do. I'm lucky as I can go out, but there's nothing for the other residents." Others told us that they were often bored because there was nothing to do. On the second day of inspection two people living at the service asked one of the inspectors if they could take them out as it was a nice day. We enquired as to when they had last been taken out by staff and they replied that it had been some considerable time. Two relatives told us that they were concerned as to the lack of activities available for people living at the service. One relative told us, "There's absolutely nothing for [name of relative] to do here – they just sit here in the lounge with the TV on. They did put on an entertainer once, but that hasn't happened for some time now."

Our observations showed that there was a lack of social stimulation available for people, particularly for people living with dementia. Where activities took place, these were short lived, for example, on the 29 March 2016 three people in lounge one were observed to play a game of darts, however this lasted for a period of 15 minutes. No other opportunities were undertaken to engage people with social activities during the two day inspection. Staff confirmed that they were frustrated and were unhappy that they did not have the time to sit and talk with people or to spend quality time with them so as to meet their social care needs. In addition, there was no indication that reminiscence, including memory boxes, objects of reference and life story work was used to help trigger memories. This meant that people were not encouraged to keep active or to stay involved in their surroundings.

These failings are a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints process and procedure in place that identified how people could raise concerns and what would happen. People living at the service and those acting on their behalf confirmed that they would feel comfortable and able to make a complaint if the need arose.

On the 31 March 2016, the registered manager advised that no complaints had been made at Melrose House within the preceding 12 months. On review of the service's complaints log this confirmed what the registered manager had told us. However, following the inspection we spoke with one relative. They confirmed that they had made a complaint to the registered manager in August 2015, about their relative's missing purse and the money contained within it. They told us that they had been given an assurance by the registered manager at that time that the issue would be investigated. The relative confirmed that to date they had not received a response or outcome to the concerns raised. No information was recorded to confirm that the complainant had had their concerns acknowledged or had received a response detailing the outcome and conclusion of their complaint. Although the registered manager confirmed that they were aware of the concerns raised, evidence of the investigation, action taken and outcome were not available.

Additionally, consideration had not been taken to report the theft to the police and no rationale was provided for this.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Our findings at this inspection showed that although the registered manager was available Monday to Friday and 'on-call' at weekends, there was a lack of clarity and understanding of their key roles and responsibilities in leading the service so as to drive improvement and this was further exacerbated by the involvement of an external consultant who was employed by the registered provider. We concluded that the service was not being effectively run for the benefit of people using the service and was not run in line with best practice guidance or with the provider's own policies and procedures. The registered manager did not have sufficient time available to enable them to undertake their management role effectively as they spent the majority of their time included in the care staff numbers. Our observations showed that responsibility by the seniors for leading each shift was inconsistent and staff were not being supervised properly.

The registered manager and staff told us that there was a lack of effective communication at all levels. Not all staff felt able or comfortable to question practice. When questioned further some staff felt that there was no point as they did not believe that concerns raised would be dealt with by the registered manager or organisation or taken seriously.

People experienced poor care outcomes because of the lack of robust quality monitoring and it also meant that there was a lack of consistency in how well the service was managed and led. The registered manager confirmed that the only formal audits in place related to medicines management and infection control. Whilst the medication audits showed that there were no corrective actions required, the infection control audits for December 2015, January 2016 and February 2016 showed that corrective actions were required. For example, all three audits made reference to some of the furniture at the service not being in a good state of repair and not being clean. There was no information to show that the actions highlighted had been addressed or that there was a scheme of delegation to review the issues raised. These audits were further ineffective as they did not highlight the poor state of cleanliness and repairs that were required in the service's kitchen during our inspection.

Systems in place did not ensure people's safety or mitigate risks relating to their health, safety and welfare of people using the service. Where strategies were in place it was evident that these were either not working, not being completed or not being followed. There was no evidence to show that the provider's own quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety for people using the service was compromised, to drive improvement and to respond appropriately. In particular, we found that the registered provider was failing to ensure that people's needs were assessed prior to admission and that people's care records included all of an individual's specific care needs and the support to be provided. Risk assessments relating to the health, safety and welfare of people living at Melrose House did not include plans for managing and mitigating risk. Equipment at the premises had not been maintained properly or ensured people's safety.

The provider did not have an effective system in place to review staffing levels so as to determine that the deployment of staff was suitable to meet people's needs. This lack of ability to assess the suitability and ongoing skills levels of staff meant that the management of the service could not be assured that people

were being cared for safely and their needs met as required. People using the service were not supported to participate in social activities. There were gaps in staff training and staff had not received appropriate supervision and appraisal. We found that complaints management was not being operated effectively so as to safeguard people or demonstrate appropriate actions taken. Additionally, effective recruitment procedures were not in place to safeguard people. Had there been a more effective quality and governance process in place, this would have identified the issues we identified during our inspection.

Staff meetings were held so as to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service. Minutes of all meetings undertaken to date were not readily available to confirm the matters raised and discussed or the actions highlighted. In addition, there were no action plans completed to evidence how issues raised were to be addressed, the dates to be achieved and if these had been resolved or remained outstanding. For example, an issue relating to people's laundry either being misplaced in others bedroom or missing was recorded in November 2015. At the relatives meeting in December 2015 the same issue about the service's laundry arrangements was also highlighted. Relatives spoken with as part of this inspection confirmed that this remained outstanding and had not been addressed.

The registered manager confirmed that the views of people using the service, those acting on their behalf and stakeholder had not been completed within the last 12 months. No rationale was provided as to why this had not been done.

These failings were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found that appropriate arrangements were not in place to ensure that people's assessments included all of their care needs or provided an accurate record of care and support provided. The provider had not protected people against the risks of receiving care and support that was inappropriate and did not meet their needs. This was in breach of Regulation 9(1)(a)(b) and (9)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Melrose House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all care and support for people using the service was provided in a safe way. Risks were not always mitigated to ensure people's safety.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Melrose House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services were not protected by the providers arrangements to ensure that the premises and equipment were properly maintained.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Melrose House.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We found that the provider did not have effective systems in place to deal with comments and complaints. This referred specifically to not considering fully or responding appropriately to comments and complaints.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Melrose House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not protected people against the risks of inappropriate or unsafe care as the arrangements to assess and monitor the quality of the service provided was ineffective.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Melrose House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected by the providers recruitment procedures. This was in breach of Regulation 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Melrose House

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of staff deployed so as to meet people's care and support needs. Additionally, the provider had not ensured that staff's training, learning and development needs had supported them to fulfil the requirements of their role to meet people's needs. This was in breach of Regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Melrose House.