M Rashid

Melrose House

Inspection report

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

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

Date of inspection visit:
07 March 2017
13 March 2017
14 March 2017

Date of publication:
11 May 2017

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

Following comprehensive inspections to the service in March 2016 and September 2016, the service attained an overall quality rating of 'Inadequate'. As a result of our concerns the Care Quality Commission took action in response to our findings by placing the service into 'Special Measures' and amending the provider's conditions of registration. This included the provider not being able to admit anyone new to the service. However, following a further inspection to the service in December 2016, the quality rating of the service was judged to be 'Requires Improvement' as a result of significant improvements made at that time. The Care Quality Commission agreed with the provider and registered manager that admissions to the service could be reinstated but only with the 'Commission's permission. However, at this inspection we found that those improvements had not been sustained or maintained.

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

This inspection was completed on 7, 13 and 14 March 2017. There were 23 people living at the service when we inspected.

The overall rating for this provider is 'Inadequate'. This means that it has been placed back 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 at the time of this inspection and had been registered with us since 6 February 2017. 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. Quality assurance audits carried out by the deputy manager were not robust, as they did not identify the issues we identified during our inspection and had not identified where people were placed at risk of harm or where their health and wellbeing was compromised. The provider and registered manager had not monitored progress in relation to the above so as to improve the quality and safety of services, and take appropriate action where progress was not achieved. In particular, the provider and registered manager had not ensured that information was accurate and properly analysed or that the person delegated to undertake this role was skilled and competent.

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 and risk assessments had not been developed for all areas of identified risk. The management of medicines was not consistently safe as people did not always receive their medication as prescribed and medicines were not stored as safely as they should be.

Whilst people told us they were safe and relevant agencies had been notified of any safeguarding concerns, the provider's arrangements for the safekeeping of people's money were not always appropriate. The procedures and processes relating to the financial management of people's monies were not protected or safeguarded and significant improvements were required. As a result of our concerns we raised a safeguarding alert with the Local Authority.

Suitable arrangements were not in place so that dirty laundry was handled with care and eliminated the potential spread of infection. Poor infection control practices by staff were observed. Staff were seen to walk through the laundry as part of taking a short cut from the kitchen to the food storage cupboard. Laundry items and soiled laundry items were not segregated and water soluble red alginate bags were not being used. Some items of furniture and floor surfaces were also no longer impermeable.

Appropriate arrangements had not been put in place to ensure the newly appointed deputy manager or staff that had been promoted to a senior care role, had received a robust induction relating to their role and lines of responsibility. Although staff had received an annual appraisal of their overall performance, aims and objectives had not been set.

The premises were not 'fit for purpose,' particularly for people living with dementia. People were not living in a well maintained environment as many areas of the service required redecoration and some items of furniture, fixtures and fittings required repair or replacement.

People and their relatives were not fully involved in the assessment and planning of people's care.
Not all of a person's care and support needs had been identified, documented or reviewed to ensure these were accurate and up-to-date. 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. Improvements were needed in the way the service and staff supported people to participate in community based social activities of their choice and ability and activities particularly for people living with dementia.

People did not consistently receive a service that was caring or care that met their individual needs. Improvements were needed to ensure people using the service were treated with respect and dignity. Although people had had their capacity to make decisions assessed, staff did not always understand the importance of giving people choices.

Arrangements were in place for staff to receive appropriate training opportunities and the majority of

mandatory training for staff was up-to-date. Although staff told us that staffing levels at the service could be variable, staffing levels and the deployment of staff during the inspection were seen to be satisfactory. People were supported to have enough to eat and drink. People were supported to maintain good health and have access to healthcare services as and when required.

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.

Not all risks were identified in relation to people's health and safety or appropriately managed or mitigated so as to ensure people's safety and wellbeing.

The management of medicines was not safe as people did not always receive their medication as prescribed and medicines were not stored as safely as they should be.

Suitable arrangements were not in place so that dirty laundry was handled with care and eliminated the potential spread of infection. Poor infection control practices by staff were observed.

Although people told us they were safe and relevant agencies were notified of any safeguarding concerns, the provider's arrangements for the safekeeping of people's money were not always appropriate. We found the procedures and processes relating to the financial management of people's monies were not protected or safeguarded.

Although people's comments about staffing levels were variable, there were sufficient numbers of staff available and the deployment of staff was suitable to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received a robust induction for their relevant role. Although staff had received an annual appraisal of their overall performance, aims and objectives had not always been set and improvements were required.

The premises were not fit for purpose, particularly for people living with dementia.

Although the majority of people who used the service had had their capacity to make decisions assessed, staff did not always understand the importance of giving people choices and respecting their wishes.

Staff supported people to meet their nutritional needs. People were supported to access healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although people were complimentary about the care and support provided, observations showed that people did not consistently receive a service that was caring.

No evidence was available to show that people using the service or those acting on their behalf had been involved in the development and review of their care plan.

Staff did not always respect people's dignity or treat them with respect.

Is the service responsive?

Inadequate

The service was not responsive.

Not all people who used the service had a full care plan in place to detail their care and support needs following their admission to the service. 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.

Although 'in house' activities were provided, provision and opportunity was not afforded for people to access the local community and improvements were required.

Complaints were well managed and demonstrated that issues raised were taken seriously and acted upon.

Is the service well-led?

Inadequate

The service was not well led.

Although systems were in place to regularly assess and monitor the quality of the service provided, improvements were required as they had not highlighted the areas of concern we had identified.

Quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance and to drive improvement. There was a lack of oversight by the provider and registered manager to monitor progress and take

appropriate action.

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 checked 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 7, 13 and 14 March 2017 and was unannounced. The inspection team consisted of two inspectors. The inspectors were accompanied by an expert by experience on 13 March 2017. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

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 13 people who used the service, two relatives, four members of staff [including two senior members of staff], the person responsible for providing social activities at the service, the provider, the registered manager and the deputy manager.

We reviewed eight 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 quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

At our previous comprehensive inspection to the service on 12 December 2016, we found risk assessment strategies to keep people safe were not as effective as they should be and further improvements were required. Arrangements for the safe management of medicines required development as discrepancies relating to staff's practice and medication records were apparent.

The provider's action plan in response to the above was received on 21 March 2017 following a request for this information to be made available. This provided detail on their progress to meet regulatory requirements. However, at this inspection we found that the improvements they told us they would make in relation to risk and medicines management had not been made.

At this inspection we found that risks were not always identified and suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

The bedrail for one person was observed to not be fitted properly and was unsuitable for a metal framed bed. This was because the gap between the bedrail, the bed and the mattress was too big and this posed a potential risk to the person of their head, chest or other limbs being trapped. The bedrail was not secure and the design of the bedrail with the metal framed bed permitted the bedrail to move away from the side of the bed and mattress, creating a potential entrapment hazard. We brought this to the registered manager's attention at the time of the inspection and they agreed with us that the bedrail was not appropriately fitted or suitable for this sort of bed and that staff, including members of the management team had failed to recognise the potential risks or dangers of this being in place. An internal investigation was undertaken by the registered manager and this highlighted that the bedrail had been fitted by a senior member of staff who had not been trained in the safe use of bedrails. Additionally, no other members of staff had received training or instruction in this area. Although the bedrail was removed following the inspector's intervention, the internal investigation found that this item of equipment had been in position since 8 August 2016. Alternatives to the bedrail had not been considered and the risk assessment relating to bedrails dated 8 August 2016 was not robust. The risk assessment had not considered if the bedrail was suitable for the bed, if the bedrail was an appropriate solution or could the use of the bedrail increase the risks to the person's health, safety and wellbeing.

The bedrail for another person did not ensure their safety as their daily care notes recorded three occasions over a one week period, whereby the person had got either one or both of their legs trapped between the bedrail, the bed and the mattress. The daily care notes recorded on one occasion that the person had sustained a red mark to their leg. Staff spoken with were aware of these incidents but had failed to do anything about it, for example, to review the use of the bedrails so as to ensure the person's safety. One member of staff confirmed there had also been other occasions where the same person had attempted to exit the bed by positioning themselves at the bottom of the bed. The staff member advised that a chair was placed at the bottom of the bed for the person's safety at these times. There was a lack of understanding that the placing of the chair would have limited the person's freedom of movement from the bed and potentially still placed them at risk should the person have attempted to climb out of the bed and over the

chair. Staff told us that the deputy manager was made aware of the incidents but no action had been taken. As detailed above alternatives to the bedrail had not been considered and the risk assessment relating to bedrails dated 8 August 2016 was not robust.

The same person was assessed as at high risk of developing pressure ulcers. We checked the setting of their pressure relieving mattress that was in place to help prevent pressure ulcers developing or deteriorating. Although others living at the service had pressure relieving equipment in place that automatically self-adjusted according to the person's weight and movement patterns when in bed, this person had a pressure mattress that relied on staff setting this correctly. We found that this was incorrectly set in relation to the person's weight on the second and third day of inspection. The pressure mattress setting for this person was fixed on setting four and this was for a person who weighed 91 kilograms; however the person's weight records showed they weighed 69.9 kilograms. Although the person did not have an existing pressure ulcer, we could not be assured that the amount of support the person received through their pressure relieving mattress would aid the prevention of pressure ulcers developing or deteriorating further. Furthermore, records to confirm if the air mattress was on the correct setting or not were not being monitored or completed.

On the second day of inspection one person was sat in a small lounge on their own from 10.10 a.m. to 11.10 a.m. inclusive. During this time the person was repeatedly observed over a 50 minute period to be sat on the edge of their chair and to make repeated attempts to stand using a side table and the arm of their chair. Although a member of staff told the person at 10.30 a.m. that they would return with another member of staff to provide manual handling support so as to place them further back in their chair, this did not happen until 40 minutes later. The person's care plan relating to 'maintaining a safe environment' and 'falls' confirmed that they were at risk of moving to the edge of their chair and this could result in them falling. The rag rating risk level was identified as 'Red' and to mitigate this risk, the person was to be checked every 30 minutes and a chart to evidence this to be completed by staff. Staff were unable to provide the charts for the 11 and 12 March 2017 and on 13 March at 1.55 p.m. the last entry recorded was 10.30 a.m. The above demonstrated appropriate measures to mitigate the risk to the person of falling from their chair were not effective and being acted upon by staff in a timely manner to monitor their safety or to safeguard the person.

Staff told us and records confirmed for two people that they had a catheter fitted. No risk assessment was completed detailing suitable control measures to mitigate the risk or potential risk of harm for either person. For example, the potential risk of harm to the person, such as, the development of urinary tract infections, bladder spasms, leakage around the catheter site which could be a sign that the catheter was blocked and pulling the catheter out. However, daily care notes over a four week period for one person showed they had pulled out their catheter on four separate occasions and support had to be sought from a healthcare professional to have the catheter reinserted. Daily care records for the other person also showed there had been occasions whereby they had been observed to attempt to disconnect their catheter tube and to tamper with the catheter, resulting in their urine being emptied in a urine bottle or on the floor. Neither care plan had been updated to reflect the above risks.

Environmental risks, for example, those relating to the service's fire arrangements were in place. Although the above was completed, the deputy manager confirmed that the fire risk assessment dated 8 August 2016 had not been updated to reflect, that since February 2017 one person was receiving oxygen therapy and oxygen equipment and cylinders were being stored on the premises. A procedure was not in place for informing the emergency services of the location of the oxygen if they were required to attend in the event of a fire. Additionally, the fire risk assessment had not been updated to reflect that since our last inspection to the service in December 2016, stair gates had been fitted, which are a fire exit route. Following the inspection

we spoke with a fire officer from Essex County Fire Service and they confirmed that the above should have been recorded and included within the fire risk assessment.

Suitable arrangements were not in place so that dirty laundry was handled with care and eliminated the potential spread of infection and poor infection control practices by staff were observed. Staff were observed to walk through the laundry as part of taking a short cut from the kitchen to the food storage cupboard. Laundry items and soiled laundry items were not segregated and water soluble red alginate bags were not being used. Laundry was observed to be placed and transported in large black plastic bags. The staff member responsible for the service's laundry told us that this was common practice. This meant that appropriate arrangements were not in place so as to minimise contact and prevent the spread of infection to laundry staff or contamination of the environment. The latter was brought to the registered manager's attention and on the third day of inspection water soluble red alginate bags were made available for staff to use. There was no evidence to show that the laundry area was 'damp-dusted' on a daily basis. The work surfaces were dirty and dusty and clean laundry was noted to be placed on top of these. There was no identified hand washing facilities in the laundry space and on the second day of inspection there was no available hand-wash or paper towels for staff's usage.

We found two bedrail bumpers were worn and ripped and no longer impermeable. Some items of furniture and floor surfaces were also no longer impermeable, for example, the surface of laminate flooring in one person's bedroom had been compromised at the joins and the surfaces of some people's furniture, such as, bedside cabinets were broken and cracked. This meant there was a risk that the surface was no longer impermeable and could contribute to the spread of infection.

Although people told us they received their medication as they should and at the times they needed them, the arrangements for the safe management of medicines required improvement. On the first day of inspection, medicines were not stored safely for the protection of people who used the service. Although one person was admitted to hospital two days prior to our inspection, on inspection of their bedroom the bedroom door was not locked. Three inhalers were on a table and a medication pot with three tablets in it was placed next to the inhalers. This meant that medicines were accessible for people not authorised to have access to them.

We found a number of discrepancies relating to staff's practice and medication records. We looked at the records for 10 of the 23 people who used the service. The Medication Administration Record [MAR] for one person showed that the code 'NR=Not Required' was recorded on 13 March 2017 for one medication. However, the MAR form stated that this medication was prescribed. The rationale for the medication being omitted was not recorded on the reverse of the MAR form, the medication remained in the blister pack and senior staff on duty were unable to provide a rationale for this omission as it related to night staff. The MAR form for another person showed over a 27 day period, they only received three doses of one of their medicines. Neither the senior member of staff on shift, deputy manager or registered manager could provide a rationale for this. This meant not all people using the service had received their prescribed medication in line with the prescriber's instructions.

One person required oxygen therapy via an oxygen concentrator and portable oxygen. Although the registered manager told us the person could self-administer their oxygen, a robust risk assessment had not been completed to assess their ability to do so correctly and safely. Additionally, the registered manager confirmed that although they were aware that the oxygen provided was a prescribed medical product, a Home Oxygen Order Form [HOOF] which contains details of how the oxygen should be used had not been sought or retained. The administration of oxygen is a specialised technique and only people who have been trained should deal with supporting the person with their oxygen therapy and to check the equipment to

ensure it is in good working order. The registered manager stated that as far as they were aware, four members of staff and the deputy manager had received training in the use of oxygen; however this had not been recorded and did not include night staff.

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

The staff training information provided to us showed that all staff employed at the service had up-to-date safeguarding training. Staff were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. 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. And although this was the case for most staff spoken with we found concerns about the management of people's monies.

Prior to our inspection we were formally notified by the registered manager of an incident in December 2016, whereby a substantial amount of money relating to one person using the service had gone missing from within the service. Although an internal investigation had been undertaken and completed by the registered manager, we found the provider's arrangements for the safekeeping of people's money was not appropriate or secure. A review of six people's money was checked as part of this inspection. The deputy manager told us they were responsible for overseeing people's finances but had received no training or guidance in this area prior to being delegated this task. We found the procedures and processes relating to the financial management of people's monies were not protected or safeguarded. Not all transactions were recorded and maintained, receipts were not evident for all expenditure and monetary balances were not accurate. For example, the monetary balance for one person as detailed on the 'Record of Residents Money' read £162.50, however the actual balance available was £52.50 and no receipts were evident for seven out of nine transactions. Where 'Incidentals' or 'Shopping' or 'Misc Shopping' were recorded, a breakdown of expenditure was not provided. In total, four out of six people's monetary transactions were found to be inaccurate. As a result of the above, a safeguarding alert was raised by us to the Local Authority.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's and relative's comments about staffing levels at the service were variable. One person told us, "The staff are always so busy." Another person told us, "The girls [staff] are all good here. We have a laugh, but sometimes they [staff] come when they like to answer the buzzer, a long time sometimes." One relative told us, "I do think there is a staff shortage at weekends." Staff told us that staffing levels, as told to us by the registered manager were maintained and that they were able to meet people's needs. Observation throughout the inspection showed that the deployment of staff was suitable to meet people's needs.

The registered manager confirmed that no new members of staff had been appointed since our last inspection on 12 December 2016. We were therefore not able to determine or check if the provider's recruitment procedures were being operated effectively so as to safeguard people living at the service. Although we were unable to determine this regulatory requirement, neither the maintenance person nor the hairdresser had had a Disclosure Barring Service [DBS] check. This was confirmed as accurate by the registered manager. Although a rationale was not provided by the registered manager as to why these had not been already completed, the registered manager provided an assurance that DBS checks for both people would be initiated as soon as possible.

Inadequate

Is the service effective?

Our findings

At our last inspection on 12 December 2016, we found that suitable arrangements had not been put in place to ensure the newly appointed deputy manager or staff that had been promoted to a senior care role, had received a robust induction to these challenging responsibilities. As a result of this we wrote to the registered manager to request additional information relating to the arrangements they would put in place to ensure staff as detailed above received a comprehensive induction for their designated role.

The written response received from the registered manager told us that an induction for the above members of staff would be developed by the end of December 2016. The registered manager stated an induction would be implemented and completed by 30 April 2017 and 30 June 2017 respectively. However, at this inspection the registered manager confirmed that an induction had not been devised, implemented or completed for these staff, despite stating to us that the deputy manager and some senior members of staff did not have the skills or competence for their role so as to be effective. The rationale provided was, "There has been so much to do, I have not had the time." Additionally, no induction had been completed for one member of staff who had returned to the service following a 12 month period of absence. Although the member of staff had previously been employed at the service, a lot of changes had taken place from within the service, for example, new senior management team including a new manager had been appointed and a number of new procedures and processes had been implemented. The provider and registered manager had not monitored this to ensure that effective arrangements and systems were in place and this had resulted in the staff responsible for aspects of the safe running of the service not being able to complete these tasks as they lacked the guidance and skills to do so. This has negatively impacted on the effective delivery of care to people and management of safe arrangements within your service.

Staff confirmed and records showed they had received supervision at regular intervals. However, the registered manager verified they had not yet received supervision since being appointed as the manager in October 2016. The registered manager told us that no provision had been made by the provider or by them to be formally supervised but suggested this could be undertaken by either the provider or deputy manager for the future. The latter was not judged appropriate, particularly as the registered manager did not believe the deputy manager to have the appropriate skills or competence for their role.

Staff told us and records confirmed that staff employed longer than 12 months had received an appraisal of their overall performance for the preceding 12 months. Although staff had received an annual appraisal of their overall performance, we found that aims and objectives for the next 12 months had not always been set. Where these were in place, information recorded was seen to be simplistic as it provided no specific information as to how the areas for further development over the next 12 months were to be met. For example, the sole aim recorded for one member of staff recorded, 'To be on top of every situation.' No information was recorded as to how this was to be accomplished or monitored. Where aims and objectives were not set, the provider wrote to us following the inspection to advise that not all staff wished to set objectives. This showed that good practice arrangements for the above required improvement so as to ensure that clear objectives were set for individual staff members. This is so the provider can assure themselves that objectives set are aligned to what they as a provider wish to achieve for the service.

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

Little thought had been put in place by the provider to maximise the suitability of the premises for the benefit of people living with dementia. Walls were painted a similar colour with little contrast and lighting was poor. There was limited signage available to help people to orientate themselves and did not follow best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people to recognise their own bedroom. For example, several bedroom doors had a peeling sticky label to denote the person's name. Some items of furniture, fixtures and fittings required repair or replacement, for example, door handles on doors or drawers were loose or missing, lighting in some people's room was not working, radiators on the second floor had not been working and several curtains were hanging and no longer secured to the railing. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. Where the latter was in place, these were not accurate to the time and day. In addition, there were few memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment. We discussed the above with the registered manager and they told us that they felt embarrassed and ashamed when showing people round the service because of the poor standard of the premises.

Two people had experienced problems with their heating. One person told us, "My room is so cold. The radiator stopped working ages ago. I have a small fan heater but it's been very cold up there. I live on the top floor and spend a lot of time in my room." They further told us that their radiator had not been working throughout the winter season. We found their bedroom to be cold and no heating emitting from the radiator in their bedroom. The registered manager accompanied us and confirmed that the radiator was cold and not emitting any heat into the bedroom. The registered manager arranged for the service's maintenance person to attend the service immediately. The inspectors were advised prior to them leaving the service that this issue had been resolved and was due to an airlock in the central heating system. Another service user told the registered manager that they too did not have a working radiator in their bedroom. They were overheard to tell the registered manager, "I had told someone, but I don't know who. No-one had done anything about it." The person was unable to tell the inspectors how long this had been like this.

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

Our observations showed staff did not always understand the importance of giving people choices and respecting their wishes or how to support people that could not always make decisions and choices for themselves. For example, people were not always routinely given a choice of hot or cold drinks, despite a variety of drinks being readily available. One person was routinely given tea to drink and yet following a discussion with us stated they also liked coffee, but this was not offered by staff.

Staff confirmed they received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities. The staff training matrix provided to us by the registered manager showed that all staff had received mandatory training or refresher training in 2016, with the exception of basic first aid and food hygiene. However, improvements were required to ensure staff also received more specialist training relating to the needs of the people they supported. This referred to dementia awareness and training relating to people's specific medical conditions, for example, Diabetes and Parkinson's. This was discussed with the registered manager following our previous inspection to the service in December 2016. An assurance was provided that the additional training would be provided in the future, however there was no evidence to show this had been provided. And although regular training was provided, we were concerned about staff practices and their lack of understanding of basic health and

safety processes such as carrying food through the laundry area and not using the appropriate bags to prevent cross infection when washing soiled laundry. We were further concerned that staff did not seem to understand the importance of safety checks for certain people and did not seem to consider their duties in terms of supporting people who required additional support or reporting to management when people experienced problems with their heating or other issues.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were able to demonstrate a knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Records showed that the majority of 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. Nonetheless, an assessment had not been considered or completed where people had an alarm mat in place to alert staff when they got out of bed to mobilise. This showed that a management plan had not been completed to confirm that this decision was in the person's best interest and the least restrictive option available.

People were generally positive about the meals provided. One person told us, "We have a good chef here – excellent food." The dining experience was satisfactory and the majority of people ate independently. 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 had the use of specialist beakers. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. People were not rushed to eat their meal and positive encouragement to eat and drink was provided by staff. Where people took their time to eat, they were not rushed or hurried by staff.

Although the nutritional needs of people were identified and regular checks of their weight completed, where people were at nutritional risk and required their nutrition and hydration needs to be monitored and recorded, records of the food provided were not always completed in sufficient detail to enable anyone inspecting the record to determine if the person's diet had been satisfactory.

People's care records showed that their healthcare needs were recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital and GP appointments and District Nurse.

Requires Improvement

Is the service caring?

Our findings

People using the service and those acting on their behalf were complimentary about the care and support provided. One person told us, "The girls [staff] all look after me very well. They're a lovely set of girls here." However, our observations showed that people did not consistently receive a service that was caring. We also found that staff interactions with people using the service were variable. Whilst some staff demonstrated positive interactions by talking and communicating with people using the service appropriately, others did not. However, where these were positive, staff listened to what they had to say by using simple language and giving them sufficient time for the conversation to take place. Furthermore, our findings in terms of how staff supported people to ensure their 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 suitable to meet their needs.

On the first day of inspection one person was visited by a healthcare professional eight days after they were admitted to the service. An exercise regime book was provided and this included instructions by the healthcare professional as to the exercises to be undertaken at least once a day or more frequently if the person was able to tolerate it so as to enhance their mobility. Although the above was in place and instructions provided, there was no evidence in daily care notes or within the exercise diary to demonstrate the exercises were being completed. The person using the service was unable to confirm if their exercise programme was being followed. We discussed this with the registered manager and noted on the third day of inspection that a form to monitor the above had been introduced, however this was not always completed to demonstrate staff's interventions. This meant we could not be assured that the person's care needs were being met.

There was little information available to demonstrate that people using the service and those acting on their behalf were actively involved in making decisions about their care, interventions and support, other than as part of the pre-admission assessment process. There was no evidence to show that where able, people and those acting on their behalf had been involved in the development and review of their care plan. However, following the inspection the provider wrote to us and advised that some care plans had been signed by either the person using the service or by those acting on their behalf. People did not know what a care plan was and others were unable to tell us if they had been involved or not. One relative when asked whether or not they had been involved told us, "No, I've not been involved in anything like that." Another relative told us, "No, I've not seen a care plan."

Although staff were able to verbally give examples of what dignity meant to them, for example, knocking on people's doors before entering, keeping the door and curtains closed during personal care and providing explanations to people about the care and support to be provided, this did not always happen in practice. Our observations showed that staff did not always respect people's dignity or treat them with respect. For example, not all staff explained things clearly to them or gave people sufficient time to respond. This was particularly noticeable for one person who was seated in a communal lounge on their own for long periods of time. Staff would often enter the communal lounge to get an item of equipment used for undertaking

manual handling procedures without talking to them or acknowledging them. Additionally, where staff asked the person if they were alright, staff did not always look at the person or wait for the person's answer or notice that the person was attempting to speak to them. The outcome of this often resulted with the person repeatedly calling out and exhibiting anxious and distressed behaviours. When inspectors engaged and talked with them, the person became less anxious and distressed and was visibly seen to relax and become calmer.

We noticed when entering one person's room after they had eaten their breakfast that they had remnants of food on their face and on their top; however the person's plate had been removed and placed on their bedside table which was adjacent to their bed but set back a little. This showed that whoever had placed the person's plate on the bedside table had not cleaned their face, or picked up the dropped food from their top. We discussed this with the registered manager and they also told us of an instance during the inspection whereby they had observed one person with food on their clothes and staff had not noticed this. The registered manager had to bring it to staffs attention. Additionally, four people were observed to be seated in a communal lounge with a member of staff present. Over a 25 minute period the member of staff was observed to be sat watching the television and at no point spoke or interacted with any of the people using the service. We also observed that one person was left in a wheelchair and sat on a hoisting sling in the middle of a communal lounge on their own. The person was seen to look round on several occasions as they heard staff's voices in the distance. The person told us they were waiting for staff to assist them from their wheelchair to a comfortable chair. When questioned further they confirmed they had been waiting for approximately 30 minutes for this task to be completed. We discussed this with the registered manager and were overheard by a senior member of staff to describe the above scenario. The senior member of staff confirmed that the person using the service had been waiting for some considerable time to be placed in a comfortable chair but put this omission down to poor staff communication.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Staff told us that people's friends and family were welcome at all times. Relatives confirmed there were no restrictions when they visited and that they were always made to feel welcome.

Inadequate

Is the service responsive?

Our findings

Following our last inspection to the service in December 2016 and as a result of significant improvements made at that time, the Care Quality Commission agreed with the provider and registered manager that admissions to the service could be reinstated but only with the 'Commission's permission.

Prior to the first day of this inspection, the Care Quality Commission had agreed a total of four admissions. Appropriate arrangements were in place to assess the needs of people prior to admission so as to ensure that the service were able to meet the person's needs. However, although some people's care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs, others were not as fully reflective or accurate of people's care needs as they should be.

The registered manager wrote to us in December 2016 confirming the arrangements they would put in place to ensure that people using the service were appropriately assessed prior to admission and a care plan detailing their specific care needs completed. This stated that an interim care plan would be completed within 24 hours of a person's admission and a full care plan within one week of admission. However, we found that the latter had not happened. For example, although one person was admitted to the service, their care plan documentation was not completed until 12 and 13 days later. When asked if this was accurate the registered manager confirmed it was but stated they had been working on the person's care plan since their admission to the service. However, it was established that the person's care plan had remained on their computer and was not accessible to staff until 12 and 13 days later. Although an interim 48 hour care plan was in place following the person's admission to the service, this was very poor as it provided no guidance for staff as to how the care and support for them should be delivered by staff. This potentially placed people at risk of receiving inappropriate care.

The above was not an isolated case and for the second person newly admitted , their care records showed that their care plan documentation was not completed until nine and 10 days later. For the third person admitted, only their interim care plan and risk assessments relating to manual handling, falls, nutrition and pressure ulcers had been completed. No care plan documentation was in place detailing their specific care needs and how these should be met and delivered by staff. This meant that staff did not have personalised information available to them on how best to give each person the care they needed and in the way they preferred. Consequently, people may not have received care in the way that they would wish to.

We found that life histories were not completed within all care files viewed. This is used to give people who use the service and those acting on their behalf the opportunity to talk about their life experiences; recording relevant aspects of the person's past and present life. By documenting a person's past life events and developing an individual biography of that person, it enables others to develop a better understanding of the person's past experiences.

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 them becoming anxious

and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had all of the information required to support the person appropriately and to reduce their anxiety. Where information was recorded detailing the behaviours observed, the events that preceded and followed this and staff's interventions needed improvement. There was little evidence to demonstrate staff's interventions and the outcome of incidents so as to provide assurance that these were effectively being dealt with and positive outcomes were attained for people living at the service.

Although people's social care needs were assessed there was a lack of information detailing how people's social activities were to be delivered by staff. People told us they had the choice as to whether or not they joined in with social activities at the service. The service employed a member of staff who was responsible for the implementation and delivery of activities six days a week. Several people were observed to enjoy the 'in house' activity of arts and crafts on the second day of inspection. Positive engagement between the member of staff and people using the service was noted and it was evident that people enjoyed the activity provided.

However, there were few opportunities provided for people to join in, particularly for people living with more advanced stages of dementia and who required more support to benefit from occupation and stimulation. Whilst people and those acting on their behalf were generally positive about 'in house' provision, people confirmed that few opportunities were provided for them to access the local community even though the town centre, shops and cafes were but a short distance from the service. Following the inspection the provider wrote to us. Whilst we found no records to suggest that people using the service had accessed the local community since our last inspection in December 2016, the provider told us that people had. This related to people having been to the local park, shopping and visiting the local Cenotaph on Remembrance Sunday in November 2016. One person told us, "I have a couple of good friends who come and take me out, however I do spend a lot of time in my room." Another person told us, "I wish we could get out more. A carer did walk me down to the town, but I'd like to do that more often. Perhaps when the nicer weather comes we can get out more?"

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were made aware of changes in people's needs through handover meetings, discussions with senior members of staff and the manager. Staff told us that handover meetings were undertaken between each shift and were important in making sure that they had up-to-date information each day about people who used the service. This meant that staff had day-to-day information about the welfare and needs of the people they supported.

Information on how to make a complaint was available for people to access. People and their relatives or those acting on their behalf told us if they had any worries or concerns they would discuss these either with their member of family, with staff or the management team. Relatives stated they felt able to express their views about the service and in their opinion they would be listened to.

Staff told us they were aware of the complaints procedure and knew how to respond to people's concerns. Complaints management was observed to be appropriate and well maintained. This showed that complaints received had been listened to, taken seriously and acted upon.

Inadequate

Is the service well-led?

Our findings

At our previous inspection to the service on 12 December 2016, although we found the provider and manager had made significant progress to address previous identified shortfalls, not all areas had been satisfactorily addressed and further improvements were required in relation to risk management and quality assurance arrangements. At this inspection we found that many of the improvements made in December 2016 had not been sustained.

The registered manager had previously been the provider's external consultant and was appointed as the manager of the service in October 2016. The manager was formally registered with the Care Quality Commission on 6 February 2017.

The registered manager told us that the completion of audits at the service had been delegated to the deputy manager. The registered manager confirmed they had not checked these to ensure the audits were completed to an appropriate standard so as to improve the quality and safety of the service. The deputy manager told us they had not received any guidance or training relating to the completion of these since commencement of their role in October 2016. While the provider and registered manager were able to demonstrate to us the arrangements in place to assess and monitor the quality of the service provided at regular intervals, through the completion of a number of audits, we found these were not as robust as they should be.

Systems for improving the service through auditing and monitoring were not effective. These arrangements had not uncovered the issues we identified during our inspection and had not recognised where people were put at risk of harm or potential harm or where their health and wellbeing was compromised. There was evidence to show that because of this some people did not experience positive care outcomes and the lack of robust quality monitoring meant there was a lack of consistency in how well the service was managed and led. It was evident that the absence of robust quality monitoring meant that the provider and registered manager had failed to recognise any risk of harm or potential harm to people using the service or non-compliance with regulatory requirements sooner. The quality assurance system was not effective in identifying areas for improvement. Had there been a more effective quality assurance and governance process in place, this would have identified the issues we found during our inspection, identified where improvements were needed or applied learning across the service.

The deputy manager confirmed that since our last inspection in December 2016, one infection control audit had been completed in February 2017. This had not been properly completed by them as they had not recognised or identified that not all areas of the premises were clean and hygienic. For example, the lampshade in one person's room was dirty and dusty and not fitted properly and several chairs were dirty, stained and no longer permeable. The deputy manager had also not recognised or identified those systems in place to control the spread of infection, particularly in relation to the service's laundry facilities and dirty laundry not being handled with care so as to eliminate the potential spread of infection were not being followed by staff. The provider and registered manager had not monitored this to reassure themselves that effective arrangements were in place.

Although audits relating to the premises had been undertaken in December 2016 and February 2017, these had not been properly completed by the deputy manager as they had not recognised or identified that not all areas of the premises ensured that people who used the service lived in a safe and well-maintained environment. Other than stating that the premises required re-decorating and repainting, the audits did not identify that many items of furniture either required repair or replacement. For example, many headboards were not fastened and secured to individual beds and door handles to some items of furniture were missing. Neither the provider or management team were aware that three people's radiators on the second floor had not been working for some considerable time. Additionally, neither the registered manager nor deputy manager had identified that one person's bedrail was inappropriate for their bed or that another person's bedrail placed them at potential risk of injury.

The registered manager wrote to us in December 2016 advising that should the embargo on admissions be lifted at the service as a result of improvements made, an interim care plan would be completed within 24 hours and a 'full care plan' within one week of an individual's admission to Melrose House. As already detailed within the main text of the report, the registered manager had failed to follow this and did not have a system in place to check that records relating to the care and support of each person were recorded, accurate and up-to-date. Risks were not always identified and suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service. The registered manager confirmed that no audits of the care records were completed so as to ensure that accurate information was available on the care people needed. Had an audit of people's support plans including risks been undertaken, the shortfalls highlighted as part of this inspection could have been identified and action taken. This may have alerted the provider and registered manager sooner so as to ensure these were in place, information was up-to-date and information to mitigate risks recorded. The provider and registered manager had not monitored this to reassure themselves that effective arrangements were in place.

The registered manager wrote to us in December 2016. They told us that the deputy manager and staff who had been promoted to a senior care role would receive an induction relevant to their role. At this inspection we found the provider and registered manager did not have a suitable system in place to check that all staff employed at the service had received an appropriate induction that prepared staff for their designated role. This was despite an assurance by the registered manager that this would be undertaken and notwithstanding their comments about the deputy manager's and some senior staff's competence and abilities. This demonstrated that the registered manager had not completed or made the improvements they told us they would make.

The provider and registered manager did not have suitable arrangements in place to manage people's monies. As detailed within the main text of the report, we found the procedures and processes relating to the financial management of people's monies were not suitable so as to protect or safeguard their personal money. The registered manager confirmed to us that the deputy manager was delegated the task of managing people's monies and that they had had no involvement in this activity. The deputy manager confirmed that although they were allocated this task, an audit of people's monies at regular intervals had not been undertaken. This meant an accurate and complete record in respect of each person had not been maintained, assessed or monitored. The provider and registered manager had not monitored this to reassure themselves that effective arrangements and systems were in place.

Whilst clinical audits were in place in relation to the incidence of falls, pressure ulcers and people's weights, an analysis of the data had not been undertaken to monitor trends. The deputy manager confirmed this was accurate. For example, data had not been collated so as to provide a clear picture as to the increase or decrease of falls, pressure ulcers and people's weight gain or loss on any given month and the rationale for this so as to monitor potential trends.

The views of staff in relation to the management team were variable. Leadership was inconsistent as, although staff were positive about the registered manager, concerns were specifically raised about the deputy manager's attitude, their relationship with staff and their ability to discharge their responsibilities to an appropriate standard. Although the latter was raised with the provider and registered manager, we were not assured by the registered manager that our concerns and reservations about the deputy manager's skills, abilities and their ability to be an effective role model were being taken seriously or would be acted on to ensure the management approach of the service was open, inclusive and positive.

The provider told us that a weekly report was compiled by the registered manager and provided to them. This provided information to the provider about what was happening in the service. Although a record was maintained, information recorded was not robust as there was a lack of detail to evidence the topics raised and agreed actions.

Staff told us they were given the opportunity to express their views and opinions on the quality of the service through staff meetings. The registered manager confirmed that one staff meeting had been held since our last inspection in December 2016. Although a record of the meeting was recorded, including the topics discussed, where areas for improvement were highlighted an action plan had not been devised detailing how these were to be addressed, monitored and the timescales for action.

The registered manager confirmed that the views of people who used the service, those acting on their behalf and visiting professionals had been sought in December 2016, however the number of responses received had been disappointing and therefore a decision had been made to resend these with the hope that a higher number of responses would be received. The previous quality assurance surveys that had been completed in August 2016, recorded variable results and comments relating to the quality of the service provided using a scale of one to ten, with one being the lowest score and ten denoting 'excellent' and the most positive score. The results showed that whilst some improvements had been made in relation to 'in-house' provision for social activities, the lowest scores related to accessibility and opportunity for community based social activities and the facilities and decoration of the premises. Comments relating to community based social activities scored between '1' and '7' and included, 'Wanting to go out but nothing has become of it yet' and, 'More chances to go on days out or even to the park.' Comments relating to the facilities and decoration of the premises scored between '1' and '6' and included, 'Needs freshening up.' However, no action plan was completed detailing where improvements were required and how these were to be addressed.

The registered manager told us that the aims and objectives of the service were to achieve a better overall quality rating for the service and to meet regulatory requirements. We found that the registered manager did not communicate a clear sense of direction and leadership which related to the aims and objectives as told to us. For example, the registered manager's actions throughout the inspection were observed to be reactive rather than proactive. It was evident that the registered manager relied upon advice and direction from the Care Quality Commission and other external agencies to enable them to run the service in the best interest of people using the service and to achieve compliance in line with regulatory requirements. Both the provider and registered manager had failed to recognise their responsibility to identify the areas for improvement and to address these. The provider had relied on the registered manager, deputy manager and senior staff to ensure the safety and quality of the service people received. Neither the provider nor the registered manager demonstrated sufficient oversight to ensure that improvements were achieved and sustained and did not demonstrate adequate competence in running the service.

The provider and management responses to concerns had been reactive rather than proactive and throughout this and the previous inspections since 2016, they had not learnt from previous areas where

failings had been identified and had not demonstrated they were able to run the service in line with regulation without continued intervention of the Commission. Inspections completed during 2016 and 2017 showed continued themes of concern in relation to the management of risk within the service which the management had not recognised, their systems had failed to identify and they were unable to show that they were proactively approaching weaknesses within their quality and governance systems to keep people safe.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.