Malhotra Care Homes Limited

Melton House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 6 November 2017.

This was the first inspection of Melton House since it was registered with the Care Quality Commission in November 2016.

Melton House accommodates a maximum of 67 older people, including people who live with dementia or a dementia related condition, in one purpose built building. At the time of inspection 44 people were accommodated at the service.

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.

The home was well maintained and provided a pleasant, spacious and bright living environment for people. We have made a recommendation about the service following best practice for equipping the environment for people who live with dementia to help them remain orientated.

People and staff appeared happy in the home. There were sufficient staff on duty to provide individual care and to respond to people's needs in a timely and patient way. Activities and entertainment were available for people

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff received other appropriate training and they were supervised and supported. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Staff had an understanding of the Mental Capacity Act 2005 and best interests decision making, when people were unable to make decisions themselves.

People were involved in decisions about their daily care requirements. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

Staff upheld people's human rights and treated everyone with respect and dignity. Efforts were made to help people communicate their needs and wishes, if they did not communicate verbally.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems

were in place for people to receive their medicines in a safe way. People received a varied and balanced diet to meet their nutritional needs.

There were some opportunities for people to engage with the local community and all people were supported to maintain relationships that were important to them.

Relatives and staff spoke well of the registered manager and said the service had good leadership. There were effective systems to enable people to raise complaints, and to assess and monitor the quality of the service. People told us they would feel confident to speak to staff about any concerns if they needed to. The provider undertook a range of audits to check on the quality of care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was clean, safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received supervision and training to help them carry out their role effectively.

Signage was available to promote the orientation of people who lived with dementia. We have made a recommendation about the service following best practice for equipping the environment for people who live with dementia.

People's rights were protected. Best interests decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were kind and patient.

People were encouraged and supported to be involved in daily decision making.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. There was a good standard of record keeping to help ensure people's needs were met.

There was a programme of activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. They were complimentary about the running of the home.

The home had a quality assurance programme to check on the quality of care provided.

Melton 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 6 November 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

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

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 11 people who lived at Melton House, five relatives, the registered manager, the operations manager, two registered nurses, eight support workers, one activities co-ordinator and one member of catering staff. We received feedback after the inspection from one visiting health care

professional. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for five staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People who used the service and relatives all told us that they and their relatives were safe at the home. One person told us, "I think I am quite safe here, there is normally someone around." Their relative commented, "I am very happy with how they are looking after [Name], they seem very comfortable." Another person told us, "I am safe here, if I press the button someone always comes, pretty quickly as well." A third person commented, "Staff help me with everything." Other people's comments included, "They don't always answer the buzzer very quickly, night staff answer it quicker" and "I think there are enough staff."

Staffing rosters and observations showed on the top floor four people were supported by one support worker. On the ground floor 22 people were supported by five support workers and one registered nurse. On the lower ground floor 18 people who lived with more severe dementia were supported by six support workers and one registered nurse. All staff interviewed told us they thought there were enough staff on duty. Overnight staffing levels included one registered nurse and eight support workers. The registered manager told us it was planned a second registered nurse was to work at night as occupancy levels increased.

A staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers. The registered manager told us this would be kept under review as people's dependency changed and staffing levels would also be increased as more people moved into the home as it was not yet fully occupied.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. They informed us they had received relevant training. One staff member told us, "I've done safeguarding training." Another staff member commented, "I'd report any concerns to the nurse in charge."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

Risks to people's safety had been identified and actions taken to reduce or manage hazards. Positive risk taking was encouraged and risk assessments were recorded in people's care records. The documents were individualised and provided staff with a clear description of any identified risk and specific guidance on how people should be supported in relation to the identified risk. For example, from falls, risk of choking or dehydration. Where an accident or incident did take place these were reviewed by the registered manager or another senior staff member to ensure that any learning was carried forward. For example, one relative told

us, "[Name] fell out of bed, since this event staff have moved the bed around so one side is against the wall. They [staff] have also placed a sensor on the mattress." This would alert staff if the person moved from bed when they were at risk of falling.

People were supported with their medicines safely. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines.

A monitored dosage system was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had been used with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interests' decision making adhered to the National Institute for Health and Care Excellence (NICE) guidelines as the best interests decision had been made with the relevant people. Documentation for one person showed a best interests meeting had taken place with the relevant people to agree whether administering medicines without the person knowing was in their best interests.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the positive behaviour team or the community mental health team. Staff told us they followed the instructions and guidance of the behavioural team for example to complete behavioural charts if a person displayed distressed behaviour. These were then reviewed and discussed at meetings with the team. Specialist care plans were developed by the behavioural team to help staff support the person. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

Records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors were contracted to carry out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. Records were also available to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. This was for if the building needed to be evacuated in an

emergency. The plan was reviewed regularly to ensure it was up to date.

We checked the progress and action taken with regard to the concerns raised by the fire authority about the evacuation arrangements from two fire exits to the contained evacuation area, on the lower ground floor which had been identified in August 2017. This was to check if arrangements were being made as advised by the fire authority to improve accessibility to a place of safety away from the building for people. We were informed arrangements were being made and we received written confirmation that the external work was to start on 11 December 2017 and would be completed in one week.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, which may make them unsuitable to work with vulnerable people. They had been obtained before they were offered their job. Application forms included full employment histories.

Good

Is the service effective?

Our findings

The building was bright, airy, spacious and well-decorated. Communal lounges to the ground and top floor and some bedrooms overlooked the racecourse and we were told in good weather some people enjoyed watching the racing. Appropriate signage was in place to help maintain people's orientation. For example, lavatories and bathrooms had pictures and signs for people to identify the room to help maintain their independence. Memory boxes were also situated outside of people's bedrooms and contained items of significance to the person to help them identify their room. However, signage was not visible when lift doors opened to advertise the floor the lift had stopped at.

We discussed with the registered manger and area manager that areas of visual and sensory stimulation could be developed to help maintain the involvement and orientation of people living with dementia. The communal areas and hallways although well decorated did not display decorations, including memorabilia to help people reminisce. Displays and themed areas were not available around the home to stimulate and remind people as they sat or walked around. Lounges and communal areas were not all equipped with clocks, calendars, orientation boards displaying menus, activities to remind people of the day of the week, what was happening that day, time and weather conditions. The registered manager told us that this would be addressed.

We recommend the service finds out more about current best practice regarding the design of accommodation for people who live with dementia.

Staff told us and training records showed they were kept up-to-date with safe working practices. One staff member commented, "We have face to face training." Another staff member said, "I've done dementia care training." A third member of staff told us, "There are opportunities for training." Other staff member's comments included, "My training is up to date" and "We do e learning training."

Staff members were able to describe their role and responsibilities. Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. Staff studied the Care Certificate in health and social care as part of their induction. This ensured they had the basic knowledge needed to begin work.

The staff training matrix showed that staff received training to ensure they had the skills and knowledge to support people. Staff training courses included, nutrition, dignity awareness, distressed behaviour and end of life care. However, the training matrix showed not all staff had received training in dementia care awareness, the MCA and DoLS and positive behaviour training. We were told by the area manager that there had been a turn over of some staff. We received information straight after the inspection that showed this was being addressed. Dates of planned training were provided that stated staff were to receive this training in January 2018.

Records also showed a more extensive training programme was to be provided for staff from January 2018 that included e learning and face to face training to give staff more insight into peoples' care and support

needs.

Staff told us they received regular supervision from the management team, to discuss their work performance and training needs. One staff member told us, "I have supervision every two months." Another staff member commented, "I have supervision with [Name] the manager or nurse every two to three months." Staff told us they were well supported to carry out their caring role. They said they could approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal to review their progress and work performance.

Staff told us communication was effective to keep them up to date with people's changing needs. One staff member told us, "Communication is effective." Another staff member told us, "All staff attended handover in the morning." Another member of staff said, "We have a handover morning and night." A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and wellbeing of each person.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. 33 DoLS applications had been authorised by the relevant local authority. There was evidence of mental capacity assessments and best interests decisions in people's care plans.

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They told us they received information from nursing staff when people required a specialised diet. We were informed people ordered their meals the day before and weekend meals were ordered on Friday. We discussed with the cook that with this pre-ordering system people may not remember or want what they had ordered the previous day. We were told sufficient quantities of food were cooked in case people changed their mind. We discussed these arrangements for ordering food with the registered manager and were told it would be addressed to ensure people were kept involved and orientated.

People enjoyed a varied diet and choice of meal. One person commented, "There is a good choice of main meals and desserts." Another person told us, "The food is always good and there is usually a choice between three main meals." People were offered regular drinks and snacks throughout the day in addition to the main meal. Meals looked appetising and generous portions were served. One person said, "I've had an excellent sufficient meal, as they say." Another person commented, "I enjoyed that, thank you." A third person said, "It was very nice cheesecake and cream for pudding." Other people's comments included, "The food is alright here. I like milk and I get plenty of that", "The food is pretty good", "Breakfast is not so good. I help myself to cereal. There is no toast available when I get up so I have two bowls of cereal", "The food

looks good" and "One of the things I miss is chunky vegetable broth, all you get here is creamed soup."

We observed the lunch time meals in the dining rooms. Most people enjoyed a positive dining experience. Relaxing, tranquil music was available to entertain people and to encourage people to eat their meal as they sat in dining rooms. Most people were served in the dining room and staff were available to provide support and encouragement or full assistance to people. People sat at tables that were set with tablecloths, place mats, napkins, condiments and flowers. People were also offered protective aprons. We observed at the evening meal, when the meal was served some people enjoyed a glass of wine with their meal.

In the dining rooms staff were busy but they were patient and attentive as they supported or encouraged people to eat their meal. On the lower ground floor we suggested some improvements to the meal time organisation as we observed people who were provided with total assistance were situated outside of the dining rooms and not near a table and this made it difficult for staff to balance their food and drink as they assisted them. A person with distressed behaviours became agitated as they waited and this disturbed other people. Menus were not available in written or pictorial format in the dining rooms. We discussed our observations with the registered manager and area manager who told us they would be addressed. The registered manager informed us after the inspection about improvements to people's dining experience on the lower ground floor.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. One relative told us, "[Name] has lost weight but staff are monitoring it." Another relative commented, "[Name] is eating well and has put on some weight. I think they are managing the weight." Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, GPs, mental health team, speech and language therapists (SALT)and the positive behaviour team. Records were kept of visits. The registered manager told us that a link GP from a local medical practice visited weekly to give advice and treatment where required. One visiting health care professional told us, "I find the qualified staff and care workers to be helpful and any information required is always provided in a timely manner. Any instructions that are left are followed through for people's care and treatment."

Good

Is the service caring?

Our findings

During the inspection there was a pleasant atmosphere in the home. Staff interacted well with people. People and staff were happy in the home. We witnessed many examples of staff providing support with compassion and kindness. People appeared calm and relaxed as they were supported by staff. Staff appeared to have a good relationship with people and knew their relatives as well. People and relatives we spoke with all said staff were kind, caring and patient. One person told us, "It's quite good here, I have no complaints about staff." One relative commented, "Staff take good care of [Name], they are very good." Another relative said, "I think [Name] is happy here." Other relatives' comments included, "I have nothing but praise for the staff", "I would recommend this home to anyone" and "The girls [staff] are all very helpful here", "Both our children are happy with [Name]'s care" and "I can go home and relax as I know [Name] is being well cared for."

Written information was available that showed people of importance in a person's life. Relatives were involved in discussions about their family member's care and support needs and they could approach staff at any time. One relative commented, "I'm kept fully informed of how [Name] is." Another relative said, "I'm kept informed of any problems."

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. A relative commented, "[Name] is always dressed well and is clean and tidy, if [Name] spills anything on their clothes staff change them immediately." Another relative commented, "[Name] is always tidy and well-dressed, they have their hair done every week." Staff knocked on people's doors before entering their rooms, including those who had open doors. Staff received training to remind them about aspects of dignity in care. The provider's information return (PIR) also stated it was planned a dignity champion would be appointed from within the home to promote dignity awareness.

Staff interacted in a caring and respectful manner with people. They acted with professionalism and compassion. When staff carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and sympathetic manner. Support workers were caring and patient. For example, they talked gently to a person and reassured them as they assisted them.

Staff were given some basic training in equality and diversity to help them recognise the importance of treating people as unique individuals with different and diverse needs. They were aware of and respected the cultural beliefs and traditions of people including their dietary needs.

People were encouraged to maintain their previous interests and hobbies. Care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes and dislikes. For example, 'I like listening to classical music.'

People who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. Staff we spoke with had a good

knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff told us they also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. One person commented, "I can choose my meals." Another person told us, "I can get up when I want in the morning." A third person told us, "I prefer to stay in my bedroom." Other people's comments included, "If I want a bath or a shower I have to go on a list." Staff took time to listen and observe people's verbal communication. We heard staff ask people for permission before supporting them, for example with personal care or assisting them to the dining room.

We were told the service used advocates as required and if there was no family involvement. Advocates can represent the views for people who are not able to express their wishes. Information given to the person before they started to use provided information about advocacy services that were available and how they could be accessed.

Good

Is the service responsive?

Our findings

People and relatives confirmed there was a choice of activities available. One person told us, It is okay here, there is always something going on." Another person commented, "The activities person is very good, they have good ideas." Another person said, "I enjoy playing dominoes." Another person commented, "I would love to go out more." One relative said, "[Name] enjoys taking part in the weekly quiz."

Three activities personnel were employed to provide activities for people to help keep them entertained if they wished to be involved. A cinema room, outdoor balcony, garden area and different seating areas within the home were available for people to enjoy some quiet time or to come together and take part in group activities. A programme of activities and a regular newsletter advertised activities that were available and this included, arts and crafts, bird watching, baking sessions, quizzes, giant board games, pamper sessions, reminiscence, singing, newspapers, music therapy, movie afternoons and armchair exercises. One newly appointed activities person was very enthusiastic and had plans to involve people in activities such as gardening with raised flower beds, growing herbs, arranging domino rallies so people could chat as they played dominoes and other group games. They also planned to arrange speakers to give talks and demonstrations such as the Royal National Lifeboat Institute (RNLI). Entertainment and concerts also took place. These included a pie and pea supper, bingo, choirs performing and a local male voice choir had recently visited and people had enjoyed baking for a 'Great British Bake Off.' The hairdresser visited weekly and a local member of the clergy visited regularly. People had the opportunity to go out into the community on trips and these included luncheon trips and a visit to the garden centre was planned on the newly acquired minibus the home had access to.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people. One relative told us, "I'm kept fully aware of [Name]'s needs and I was involved in their initial care plan and it was reviewed just a few weeks ago." Another relative commented, "We always review [Name]'s needs."

Care plans were in place that provided some details for staff about how the person's care needs were to be met. For example, one care plan for personal hygiene stated, 'Prompts from one staff member for dressing as unable to co-ordinate clothes.' However, not all care plans provided detail of what the person could do to be involved and to maintain some independence. Although they contained some information, it did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. Regular staff knew people's care and support needs to deliver care in the way people wanted but documentation needed to provide more guidance to staff about how people were to be supported. This was so agency staff and new staff were as familiar and aware of people's care routines and how they liked to be supported. One person commented, "The regular staff are really good, the agency staff

are good, but they don't know enough to take over." We discussed this with the registered manager and area manager who told us it would be addressed.

Other information was available in people's care records to help staff provide care and support. For example, '[Name] needs to drink 750mls of fluids throughout the day up until supper…' Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

Care plans described how the person communicated, so staff were able to provide appropriate support and guidance to the person to reassure them. For example, one communication care plan recorded, 'Staff should be aware [Name] has poor hearing. Staff should speak clearly giving them enough time to understand and respond." Another care plan recorded, '[Name] can communicate yes or no to a simple sentence.' Guidance was available which documented how people communicated, when they may no longer be able to express their wishes and needs verbally. For example, how they may show they were in pain if they were unable to tell staff verbally that they were in pain or distressed. One care plan stated, '[Name] is usually able to communicate their needs so can make staff aware if suffering pain or illness."

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. One registered nurse told us they were studying an external course about end of life care and it was planned they would become the specialist champion within the home and work in partnership with external palliative care agencies. This would promote awareness and help ensure people received a dignified, person centred and pain free death.

People knew how to complain. People we spoke with said they had no complaints. One person told us, "I have no complaints." Another person commented, "I have no complaints about the standards here, I'm well cared for." A record of complaints was maintained and a complaints procedure advertised how to complain. It was also in place to ensure complaints were appropriately investigated. We saw compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

The home had a registered manager who had become registered with the Care Quality Commission as manager for Melton House in November 2016. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager assisted us with the inspection, together with the area manager. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and were open to working with us in a cooperative and transparent way.

The registered manager told us they were well supported by the provider. They had regular contact with them, ensuring there was on-going communication about the running of the home. Regular meetings were held where the management were appraised of and discussed the operation and development of the home.

The atmosphere in the home was lively and friendly. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. One person told us, "I think the manager is very good, they are very approachable." Another person commented, "The manager seems to get things done. They organised a new a chair for me which is so much better for my legs." People and relatives told us they were listened to by the registered manager. One relative commented, "[Name], the manager is very good, we have good liaison between the home and the family." Another relative told us, "The manager looks after me as well, they support me through my wife's care."

Staff were positive about the management of the home and had respect for them. Staff commented they worked as a team and we observed they knew what they doing as they supported people. One staff member told us, "The manager is definitely approachable." Another staff member commented, "[Name] the manager's door is always open and you can talk to them."

Staff meeting minutes were available to show the staff meetings that took place to assist with communication and ensure the smooth running of the home. One staff member told us, "We have monthly staff meetings." These included senior staff meetings, health and safety meetings and general staff meetings. Staff members told us staff meetings took place and minutes were made available for staff who were unable to attend. Minutes from a staff meeting in October showed standard agenda items included safeguarding and health and safety. Staff meetings kept staff updated with any changes in the service and to discuss any issues.

Regular monthly meetings were held with people who used the service and their relatives to obtain feedback and consult with people. Meeting minutes were available for people who were unable to attend. Items discussed included menus, activities and outings.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. They showed

action that had been taken as a result of previous audits where deficits were identified and the follow up action that had been taken. Weekly checks included for the nurse call system, fire checks and for the safe maintenance of the premises. Monthly audits included checks on staff training, medicines management, dining experience, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. health and safety and accidents and incidents. Other audits included for health and safety and infection control. All audits showed the action that had been taken as a result of previous audits.

The registered manager told us monthly visits were carried out by the area manager or compliance manager to speak to people and the staff regarding the standards in the home. They would speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Action plans were produced from monthly visits with timescales for action where deficits were identified.

The registered manager told us the provider planned to monitor the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were to be sent out annually to people who used the service and staff.