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Melrose Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Melrose Residential Home (Melrose) is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided. Both were looked at during this inspection.

Melrose is located in a residential area of Leyland, close to the town centre. The home is on three floors, with passenger lift access. Accommodation is provided in single rooms for up to 26 adults, who need assistance with personal care. At the time of this inspection there were 16 people who lived at the home. There is easy access to local amenities, such as shops, supermarkets, pubs and churches. Some parking spaces are available at the front of the home and on road parking is also permitted. There are garden areas to the front and rear of the premises.

The last inspection of this location was conducted on 27 and 28 February 2018. At that time, we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person centred care, safe care and treatment and good governance. We served two warning notices against the regulations of safe care and treatment and good governance, because these were continued breaches. Due to these failings a rating of 'Inadequate' was awarded to the domain of 'safe' and therefore the home remained in 'special measures'. This means that the service was kept under review, and was inspected again within six months of the inspection report being published. The key questions of 'effective', 'responsive' and 'well-led' were rated as, 'requires improvement', with the key question of 'caring' being rated as 'good.'

Following the last inspection, the provider developed an improvement plan to confirm how and when they were going to make improvements, in order to improve the key questions of 'safe', 'effective', 'responsive' and 'well-led' to at least 'good.'

This inspection was unannounced, which meant that people did not know we were going to visit the home. It was undertaken on 15, 16 and 18 October 2018. At the time of the inspection there was no registered manager 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 of the Health and Social Care Act and associated regulations about how the service is run.

At this inspection we found two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment and good governance. We also found three additional breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to need for consent, safeguarding people from abuse and improper treatment and staffing. A breach of regulation 18 of the Care Quality Commission (Registration) regulations was also identified, as the provider was failing to send notifications of reportable events to the Care Quality Commission.

People were supported to have some choice and control of their lives and staff supported them in the least restrictive way possible. However, systems in the service did not always support this practice, as assessments had not always been conducted in order to determine if people had the mental capacity to make decisions and to give consent for their care and support.

We found risks to people's health and safety had not always been identified and mitigated, in order to safeguard people from harm. There were also some safety issues noted during our tour of the premises. We found people's needs were not always met and people's safety was being compromised. The staffing levels were not adequate to meet the needs of those who lived at the home. This was evidenced by the excessive number of unwitnessed falls experienced by those who lived at Melrose.

We found infection control practices had improved. The environment was, in general clean throughout. Some refurbishment had been completed since our last inspection, which enhanced the environment for those who lived at Melrose.

We found some improvements had been made to the planning of people's care. However, assessed needs had not always been incorporated into the care planning process. This meant that people may have not always received the care and support they required. We made a recommendation about this.

Policies in relation to equality and diversity had not been introduced. We made a recommendation about this.

We found people who lived at the home were treated with respect and their privacy and dignity was consistently promoted. People looked happy and comfortable in the presence of staff. We observed some lovely interactions by staff members with those who lived at Melrose.

At this inspection we found that medicines were not managed safely. We assessed the systems for monitoring the quality of service provided. We found there was little oversight and leadership of the service. Quality monitoring, governance and oversight systems were not effective.

We looked at the personnel records of three staff members who were employed at Melrose. We found that recruitment practices adopted by the home could have been better. We made a recommendation about this.

Although induction programmes and a variety of training had been provided for the staff team, records showed that supervision and appraisal sessions were sporadic and not structured. We made a recommendation about this.

We found the home had not always shared appropriate information with the relevant authorities and statutory notifications had not always been submitted to the Care Quality Commission.

Meals looked appetising and were well presented and we observed a pleasant dining experience for those who lived at the home.

We found that equipment had been serviced in accordance with the manufacturer's recommendations, to ensure they were fit for use.

People we spoke with were aware of how to raise concerns, should they need to do so. A complaints procedure was in place at the home and a system had been implemented for the recording of complaints

received.

People we spoke with were complementary about the staff team. They felt that they were treated in a kind, caring and respectful manner. Most we spoke with expressed their satisfaction about the home and the services provided.

We did not see much evidence of the provision of leisure activities and people who lived at the home felt this was an area which could be improved. We made a recommendation about this.

At this inspection, although we found the plans of care to be better, further improvements were still needed. People were not always involved in planning their own care and support. We made a recommendation about this.

This service remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

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

This service was not safe.

Medicines were not being well managed and risks to people's health, safety and wellbeing were not appropriately assessed. The safety of people was not being promoted and therefore they were not protected from harm.

Staff had received training in safeguarding people. However, we found that not all incidents were being reported and procedures were not always being followed.

Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations.

The premises were clean and the control of infection was satisfactory.

Recruitment practices adopted by the home could have been better.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Records showed that new staff had completed induction programmes and training was provided for the staff team However, although supervision and appraisals had been conducted, these were sporadic and not structured.

The principals of the Mental Capacity Act 2005 had not been fully implemented and consent was not always formally sought.

The home was comfortable and meals looked appetising.

Is the service caring?

Requires Improvement

This service was not consistently caring.

People told us that staff were kind and caring. We observed good interactions between staff and the people who lived at Melrose. Staff approached people in a compassionate manner.

People were not always given the opportunity to make formal decisions about the care and support they received and policies had not been introduced about equality and diversity.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

Although pre-admission assessments had been conducted and the planning of people's care had improved, people's assessed needs had not always been transferred to the plans of care.

People were offered choices. However, some of those who lived at the home felt that the area of activities could be improved.

The use of technology could be better in order to move the home forward.

Is the service well-led?

Inadequate

This service was not well-led

There was no registered manager in post. There continued to be a lack of recorded oversight by the registered provider. As such the home had not implemented methodologies for assessing and monitoring the quality of service provided.

The views of people who had an interest in the home were sought and meetings for those who lived at Melrose, their relatives and the staff team were arranged.

The relevant authorities had not always been notified of reportable events

Melrose Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider had addressed the breaches identified at the previous inspection, if they were 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 new rating for the service under the Care Act 2014.

This inspection was undertaken on 15, 16 and 18 October 2018 and was unannounced. It was conducted by two adult social care inspectors from the Care Quality Commission (CQC), a pharmacy inspector and an inspection manager. An expert by experience was also part of the inspection team. An expert by experience is someone who has experience of the type of service being inspected. At the time of our inspection there were 16 people who lived at Melrose. We spoke with five of them and four family members.

We spoke with four members of staff and the provider. We toured the premises and observed the day-to-day activity within the home. We also looked at a wide range of records, including the care files of eleven people who used the service.

We also looked at the personnel records of three staff members, which helped us to establish the robustness of recruitment practices and the level of training provided for the staff team. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

Prior to our inspection we reviewed all the information we held about the service, including statutory notifications, which are a requirement and which tell us about any significant events. We also looked at information we had received from other sources, such as the local authority. We requested a Provider Information Return (PIR), which was submitted within the timeframe. A PIR is a document which provides us with key information and data about the service, including improvements they plan to make. We also checked progress against the provider's action plan sent to us after the last inspection. We used a planning tool to collate all this evidence and information prior to visiting the home.

Inadequate

Is the service safe?

Our findings

Everyone we spoke with said they felt safe living at Melrose. Comments we received from those who lived at the home included, "I feel very safe as there are always lots of people around to look after me. It's like being in a place with lots of brothers and sisters" and "I feel safe because I can ring the bell and someone will come to see me."

Family members we spoke with told us, "I feel [name] is safe as there are always people around. I know she doesn't have to use the stairs as there is a stair lift" and "Mum is absolutely safe. The security in and out of the building is very good. When she walks around there is always someone keeping an eye on her. Her belongings are very safe we have no worries on that score."

At the last inspection we found the provider had not ensured that a robust risk management framework had been adequately implemented and guidance from community health care professionals had not been followed in day to day practice.

At this inspection we looked at eleven care files and found that areas of risk had not been sufficiently considered. For example, we had concerns about the care of one person, who was at risk of choking and was nearing the end of her life. A specific risk assessment and care plan had not been completed and dietary advice was not being followed in day to day practice. This placed the individual at risk of harm.

End of life medications had been prescribed, but these were not received into the home for several days. There was no evidence to demonstrate the home had made an urgent request for these medicines, should the person require them to make them more comfortable. On the second day of our inspection we noted a significant deterioration in the condition of this person. We brought this to the attention of a staff member, who asked, "Do you want me to phone the relatives?" Despite this individual taking very little diet and fluid there were no recent fluid balance or dietary intake charts in place, to enable staff to accurately monitor her nutritional status. Therefore, this person's needs were not being met.

We established that appropriate pressure relief was not being provided. For example, the care plan for one person showed they needed pressure relief every hour, in order to prevent skin damage. However, this was not taking place in day to day practice and the home's risk assessment varied significantly from that completed by the district nurse. Therefore, this person was at risk of harm, due to an increased risk of developing pressure sores.

We particularly focused on the management of risk relating to people who were at risk of falls. Records showed that an excessive number of unwitnessed falls were occurring in the home. For example, one person had experienced 18 falls this year, ten of which were unwitnessed. This person's falls risk assessment had not been reviewed and appropriate professional advice had not been sought on most occasions. The care records for this person showed they had vascular dementia. However, on eight occasions following falls staff had advised them to operate the nurse call bell to summon assistance. This shows staff members had not taken into consideration the individual's cognitive impairment, which had resulted in short term memory

loss. This placed the individual at increased risk of falls and therefore greater risk of injury.

We noted this person's bedroom was at the top of a short flight of stairs, which had a metal stair-lift installed. They were not able to operate the stair lift and we were told by staff they did regularly attempt to access the stairs with their walking frame. This person fell on the stairs outside their bedroom on the first day of our inspection. We raised our concerns with the provider about this person's safety. Following the second day of our inspection the provider, with agreement from the individual and their family relocated them to a different area of the home to protect their safety.

Records showed that another two people had fallen and had sustained head injuries. However, medical advice had not been sought and there was no evidence available to show appropriate observations had taken place following these incidents. Accident reports had not always been completed and professional advice had not been sought on most occasions following falls. Care records did not always clearly identify if any injuries had been sustained. On one occasion a member of the inspection team had to intervene in order to prevent one person falling down the stairs due to dizziness, despite a member of staff telling us the person could manage and she would be 'OK.'

We found the above findings demonstrated that falls risks were not being well managed. We also found this to be the case with the risk of pressures sores, end of life care and the risk of choking.

The home did not have a clear strategy for the management of falls and the monitoring of falls was not leading to actions to reduce the risk, as there were no records of lessons learned following accidents and safeguarding incidents, despite some significant injuries being sustained, due to falls. Therefore, people's safety was not protected.

The inspectors and inspection manager met with the provider on the second and third day of our inspection to discuss the failings in relation to falls sustained by people in the home. The provider failed to demonstrate a detailed knowledge or oversight of the actions taken to reduce any future risk of harm.

We looked at environmental safety and found significant shortfalls in this area. Environmental risks were not being appropriately managed. For example, we identified some serious fire safety risks in one occupied bedroom. We immediately brought our concerns to the provider's attention, who acted immediately in order to mitigate these risks. We observed two bottles of Dettol in one person's bedroom and an iron on the floor. We were told this individual liked to do her own ironing on the floor. There was no evidence of an ironing board and the provider was unsure if a relevant risk assessment had been conducted. In one communal toilet a wooden plinth behind the toilet was loose and there was a bucket, labelled 'commode only' containing air freshener and two unlabelled bottles of liquid. Therefore, people who lived at the home, who had a mental impairment were put at risk because they had easy access to hazardous products.

At this inspection we found that medicines were not managed safely.

Medicines were not stored in line with the homes medicines policy. Maximum and minimum refrigerator temperatures were not recorded for the medicines fridge, and we found topical medicines, such as creams and ointments kept in unlocked bedrooms.

Medicines were not always administered as prescribed. There were discrepancies with records and medicine stock and one person missed five doses of a medicine for moderate to severe pain because staff failed to reorder, another did not have medicines required for symptoms at the end of life for four days after the GP had prescribed them. We found one person's eye drops were still being administered six days after their

expiry. This meant the medicine may not be as effective.

Some people had medicines prescribed to be taken when required. Instructions to guide staff to give these medicines were not always available. We saw that staff did not always record the amount administered when the dosage was variable and the time of administration was not recorded accurately when paracetamol was given. This is important to ensure a four-hour gap is observed between doses. Records when patches were applied were also incomplete.

The home had recently undertaken some medicines audits however these had not been completed properly and issues found at the inspection demonstrated that the audits were ineffective. The home did not learn from incidents and errors and we saw no evidence that staff had undertaken annual medicines competency checks.

The findings above resulted in a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

A safeguarding policy was in place at the home. However, this was not being followed in day to day practice. Records we looked at confirmed that the provider failed to report unwitnessed falls and safeguarding allegations to the appropriate authorities. Lancashire County Council's safeguarding guidance was not being used, despite a copy being present in the safeguarding file. Where records for safeguarding were seen, these were basic in their content and had very little evidence of the action taken by the provider to protect people from harm. For example, the care records for one person failed to demonstrate that the home had protected them from allegations of abuse and lessons learned were not evident. This placed the individual at risk of harm.

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

The provider told us staffing levels had recently increased and that a tool had been designed to analyse staffing numbers within the home, in accordance with dependency needs of those who lived at Melrose. However, due to care records and risk assessments not being current, it would be difficult to confirm the staffing levels accurately reflected people's needs. We established that one person, due to deteriorating health required two care staff to support her during personal care needs. However, at night time there were only two care staff on duty and therefore this could have compromised the care of this person or of others who lived at the home. It was clear from the high number of unwitnessed falls recorded that shortfalls in staffing numbers could have had an impact on people's safety.

The findings above resulted in a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Recruitment practices adopted by the home could have been better. Relevant checks had taken place. However, one staff member had a reference from a previous employer raising concerns about their suitability. There was no record of the provider investigating this further and a risk assessment had not been completed to ensure this member of staff was being monitored and was deemed fit to work with this vulnerable client group. Another employee had a reference from someone, who had not been declared on their application form. The interview notes referred to a place of work, which was not detailed on the employment history and one of the references received was from a member of their family. Therefore, the provider had not ensured new employees were deemed fit to work with vulnerable people. We recommend that the recruitment of staff be reviewed in order to ensure a more robust system is implemented.

A fire procedure was in place and a fire risk assessment had been developed in conjunction with an independent fire safety specialist. Improvements had been made to the PEEPs (Personal Emergency Evacuation Plans) since our last inspection. This helped to ensure people would be assisted to vacate the premises in the safest and most appropriate way, should this be necessary.

At the last inspection we found the provider had not ensured sufficient infection control practices had been introduced in relation to the cleanliness of the catering facilities. At this inspection we found infection control practices had improved and therefore this area of regulation 12 had been met on this occasion. The food standards agency had awarded the home a rating of level 5 for food hygiene, which is the highest standard achievable.

During our inspection we toured the premises and found the environment to be in general well maintained. We noted some refurbishment had taken place since our last inspection, although other areas of the home were in need of modernising. A structured programme of refurbishment was in place. We discussed this with the provider, as a review of this may be beneficial, to ensure completion dates are achievable.

A business continuity plan was in place at the home, which outlined what action staff needed to take in the event of an emergency situation arising. Records showed that systems and most equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to ensure they were in good working order and fit for purpose.

Requires Improvement

Is the service effective?

Our findings

Everyone we spoke with said they felt the staff were well trained. Comments we received included, "I think they are well trained, but there are some better than others"; "I have asked my relative if she is happy with her care and she is"; "I haven't seen anything I am worried about when I visit. She [person who uses the service] constantly praises the carers for what they do for her" and "The staff appear to know what they are doing. I have no worries."

Everyone we spoke with said the food was good and there was plenty of it. One person told us, "I have put weight on since I have been here. I can ask for all sorts of drinks at any time." Another commented, "The food isn't bad. You get two choices which they tell you about a couple of hours before the meal. If you don't want what you are offered they will make something else for you" and a third said "The meals are a good size so I never feel hungry. There is always a good choice even if it is sandwiches, as they provide a good variety so there is something that everyone will eat."

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

People can only be deprived of their liberty to receive care and treatment when 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).

We checked whether the service was working within the principals of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection we found mental capacity assessments had not always been conducted for those who lacked the capacity to make decisions, due to short term memory loss or an impairment of the mind or brain.

At this inspection we found little improvements had been made. For example, mental capacity assessments had not been completed when appropriate and we could not see evidence of best interest decisions being recorded. Records seen were confusing and did not clearly demonstrate people's ability to make decisions. Staff were unable to confirm which service users were being deprived of their liberty and which DoLS applications had been submitted. This placed people at risk of not having their rights upheld, because the provider failed to ensure the service was working within the principles of the Mental Capacity Act.

Consent had not always been appropriately obtained and information recorded was confusing. For example, consent forms for one person were not fully completed and the consent form in relation to care and treatment stated, 'Going to ask (name) and her family if they would like a referral to the memory clinic.'

This did not indicate if the individual or their representative were in agreement with the support this person was receiving.

This constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We examined three staff personnel records. We found induction records were present on each file. However, although some supervision and appraisal sessions had been completed, these were sporadic and lacked a structured approach. Therefore, the staff team were not being monitored or supported to develop their knowledge and skills. It is recommended that the provider introduces a more structured system for supporting staff in supervision and appraisal.

Staff we spoke with told us that the majority of training was done on-line. One member of staff told us, "I did 11 courses on-line on Sunday." However, the general consensus was that staff preferred face to face training, rather than completing it on a computer. We were told the staff training matrix was not up to date. However, there were a variety of training certificates on the staff personnel files we saw and staff we spoke with were able to provide us with good examples of training they had completed. One care worker told us that training for staff had improved and further training had been planned. We recommend that the service seek advice and guidance from a reputable source, about a staff development strategy that takes into account delivering effective supervision and training.

We observed the lunch time meal. This was a pleasant experience for those who lived at the home. Tables were set nicely with table cloths, cutlery, condiments and flowers. Age appropriate music was playing quietly in the background. People either made their way to the dining area independently or they were supported by carers, when needed.

The chef and staff members were evidently aware of people's food choices and the size of portions preferred. We saw staff members communicating well with people during lunch and helping those in a gentle manner, who needed assistance. The food served looked appetising and people told us it was enjoyable.

Care records we looked at showed a wide range of health and social care professionals were involved in the care and support of those who lived at Melrose. However, our findings at this inspection demonstrated that outcomes for those who lived at Melrose were not always effective. This was because although external professionals were involved, their advice was not always sought in a timely manner and was not always accurately recorded or appropriately followed. For example, people who were at high risk of falls were not referred to the relevant health care professionals in a timely manner, in order to reduce this risk.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with was positive about the care they received and the attitude of the staff team. Comments we received included, "They [staff] are very kind and they are fun too" and "They [staff] have been wonderful whilst I have been here. They have been very supportive helping me."

One relative told us, "The carers are wonderful at all times. When I have visited I can tell by the way they talk to all the residents that they care about them. I have never heard any raised voices" and another family member said, "They [staff] are very good. They show they care by always going the extra mile. They are aware of each of the resident's needs. They are respectful it is just the way they are."

Some care records demonstrated that people were involved in planning their own care, although this was not always consistent.

We recommend that those who live at the home or their relative, should people so wish, be given the opportunity to be involved in the care planning process

We observed people who used the service being treated equally and staff members allowing people sufficient time to complete activities of daily living. They showed kindness and compassion. No-one was rushed and we noted people appeared relaxed in their surroundings and comfortable in the presence of staff members. Those who lived at Melrose appeared to have developed good relationships with staff members. We saw some lovely interactions by staff members towards those who lived at the home.

The care plans we saw incorporated the importance of protecting people's privacy and dignity, particularly during the provision of personal care. We saw staff members knocking on people's bedroom doors before entering and supporting them to maintain their independence, as far as possible. Staff members we spoke with were able to tell us how they promoted people's privacy and dignity. They were clearly very caring and respectful towards those who lived at the home.

The Service Users' Guide provided people with information about access to advocacy services, should they wish to use this support. An advocate is an independent person who will support people with the decision-making process, to ensure that decisions are made in people's best interests.

We observed staff members giving people clear explanations and information in a discreet manner. This reassured them and encouraged them to be confident in completing daily activities.

Requires Improvement

Is the service responsive?

Our findings

Those we spoke with were not aware of their care plans. One person said, "I haven't seen a care plan, but I have never asked to see it. I am not worried as I am happy with the care I am getting" and a relative told us, "I am not aware of a care plan, but I feel very confident that they would speak to me about anything they needed to."

At the last inspection we found assessed needs had not always been incorporated into the care planning process. This meant that people could have potentially received inappropriate or unsafe care and treatment.

At this inspection we found some improvements had been made to the content of the plans of care. However, further improvements could still be made. We pathway tracked the care and support of four people who lived at Melrose. Pathway tracking is a system we use to ensure people are receiving the care and support they need.

We found that needs assessments had been conducted before people were admitted to the home, but these were very basic and did not provide the staff team with detailed information. However, the funding authority had also provided assessments of people's needs, which were more detailed. This helped the staff team to be aware of people's needs before they went to live at Melrose.

Some very detailed information was recorded in the care files we looked at, under the headings of, 'Who am I?' 'Things that are important to me', 'What people like and admire about me' and 'How best to support me'. The plans of care we saw were well written. However, only two had been reviewed within the last five months and although they clearly outlined people's preferences, including past hobbies and interests some improvements were still needed to ensure all areas of need had been considered. It is recommended that individual care plans are developed for each area of assessed need.

Some care files we saw contained 'Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)' orders. These had been developed with the individual and their family. This helped to ensure people's last wishes were followed. The care records for one person who was at the end of her life showed she wished to remain at Melrose, rather than be transferred to hospital for any treatment. However, the specific end of life care needs to support this person and her family were not clearly identified. Therefore, relevant guidance had not been provided for the staff team, which could have potentially resulted in inappropriate care and support being delivered.

The use of technology was limited in moving the service forward. This needs to be addressed by the providers, so that the home is brought into line with current assistive technology tools.

Information was easily accessible at the home, which helped people to make decisions and to obtain information they needed. The complaints procedure was displayed in the reception area of the home and it was incorporated into the Service User's Guide, available in each bedroom.

Although those we spoke with told us they had never had to make a complaint, they were aware of how to raise their concerns, should they need to do so. There had been only one complaint recorded in the complaints file since our last inspection. We saw no evidence of the actions taken as a result. There was no record of any feedback to the complainant, no investigation notes and no documented evidence of any outcome or lessons learned. It is recommended that more robust systems be implemented to ensure complaints are managed appropriately.

People we spoke with told us that activities took place. Some could tell us they had been taken out. One person commented, "There are activities now and again. There are games and singing and sometimes we do exercises. I went out once for a meal." Another said, "I like to be in my room, where I do things I like, such as puzzles. I do go to some of the activities which they have each day. We do things like colouring, exercises and dominoes, but I don't think they provide trips out." A relative told us, "Mum loves music, singing and dancing, so they put music on which she likes to dance to" and another family member told us, "She [person using the service] does take part in the activities. Recently the historical society visited. She said it was very good and free."

We observed people being offered choices and their interests were recorded within the care records. However, there was little evidence that people were supported to maintain their interests whilst living at Melrose. On the day of our inspection we saw people participating in armchair exercises for ten minutes during the morning. The television was on for the remainder of the day, although people did not appear to be interested in watching it. We established that care staff were responsible for providing activities, but this was difficult, due to people needing assistance with the provision of care. We were told the last trip out had been at Christmas 2017. However, a programme of activities had been developed, although this was basic and was not being followed in day to day practice.

It is recommended that the provision of activities be reviewed and tailored to meet the needs, preferences and wishes of those who live at the home. We recommend that the service seek advice and guidance from a reputable source, about providing suitable activities to people in the home, some of whom were living with dementia.

Inadequate

Is the service well-led?

Our findings

Some people we spoke with seemed unsure about who the manager of the home was. One person told us, "I don't think there is a manager at the moment." Another commented, "The management are very approachable and friendly. They are lovely. Very business-like, but friendly" and a third said, "The management are very approachable. I think it is a great home as everyone is so easy to speak to."

Other comments we received included, "There is a very nice atmosphere – very calm and very mellow'; "It is always relaxed. Some of the staff go around singing and they all take time to talk to the residents"; "It is a very friendly and caring place" and "As far as I have observed we are all treated fairly in the same way. There doesn't appear to be any favourites. All the staff appear to be treated well and they are happy."

At the time of our inspection there was no registered manager in post. The provider informed us that a new manager had been appointed, but relevant checks were still outstanding and therefore this person had not commenced employment at this time. Since the inspection we have been informed by the provider that the prospective manager had decided not to take up post. Therefore, the provider is re-advertising the position. We were told by staff members that the provider is attending the home four days each week until a suitable manager is appointed.

At the last inspection we found that the provider had not ensured sufficient improvements had been made to the governance and oversight systems, in order to effectively assess and monitor the quality of service provided. Following that inspection, the provider developed a detailed improvement plan.

At this inspection we found the provider had failed to ensure the service was meeting fundamental standards of quality and safety. Robust systems were not in place to ensure people were protected from unsafe care and treatment. People were at risk because medicines were not managed safely to protect them from harm. We found many areas of the improvement plan had not been met, despite the provider indicating they had.

We identified that risk assessments were missing or were incomplete and failed to reflect measures implemented to reduce any future risk. Systems to act on, report, record and investigate accidents and incidents to minimise any future risk had not been established to protect service users from potential harm.

The provider failed to ensure people received appropriate care and support. This placed people at risk of harm. There was no evidence available to demonstrate the care files were being properly analysed and audited, in order to ensure they were completed appropriately and contained all the relevant person-centred information. We identified that care records did not always reflect people's current needs.

End of life care planning had not been completed to ensure people received the care and support they needed during their final days of life. People were at risk of harm because their nutritional needs were not being met. We identified that not enough knowledgeable, suitably qualified and experienced staff were employed to protect people from harm.

We established that in the absence of a registered manager there was a lack of leadership and little oversight of the service. There were significant shortfalls in the auditing process, as audits and checks were irregular, incomplete, did not identify risk and lacked evidence to show action had been taken. They did not highlight the shortfalls identified by the inspection team. We found the provider lacked understanding and knowledge of the failings of the service and therefore governance of the home was unsatisfactory.

Our findings above constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We examined the incident and accident records and found that the Care Quality Commission (CQC) had not always been notified of reportable events, in accordance with the regulations. For example, the falls diary for one person showed they had sustained five unwitnessed falls during July 2018. This person's falls risk assessment showed they was at high risk of falling. The falls diary for this individual showed no injuries had been sustained following any of the falls and medical advice had not been sought. The day following the last fall this person had an unrelated hospital appointment, at which time a swollen ankle was noted by hospital staff, which was investigated further and a fractured ankle was diagnosed. This incident was not reported to CQC.

The care records for another person showed they had experienced an unwitnessed fall in September 2018. The person was found on the floor and told staff they had 'hurt their head'. The accident report reads, 'Unwitnessed. Found on floor. No apparent injuries only bump on head. No marks. Small skin tear to left hand; dressing applied.' A safeguarding concern form was completed several weeks later, which highlighted concerns, as the information recorded was incorrect. This incident was not reported to CQC.

This constituted a breach of Regulation 18 of the Care Quality Commission (Registration) regulations. Other notifications. We will deal with this outside of the Inspection reporting process as a separate issue with the registered provider.

The aims and objectives of the home were included in the Service User's Guide, a copy of which was retained in each person's bedroom, for easy reference. This stated, 'It is the objective of Melrose Care Home to provide care to all service users to a standard of excellence that embraces fundamental principles of good care practice.' This statement was not reflective of our findings at the time of our inspection.

Surveys were not being regularly completed for families, community professionals or staff members. Therefore, feedback was not being consistently gathered from these groups of people. However, the opinions of those who lived at Melrose had been sought in the form of questionnaires.

Records showed that regular residents', relatives' and team meetings were now being held. This enabled any relevant information to be disseminated and allowed participants to discuss any topics of interest, concerns they may have or areas of good practice within an open forum.

We did see a range of thank you notes from people who had resided at the home and their families, which all contained positive comments. Staff members we spoke with felt the care provided was of a good standard, but some confirmed the paperwork was not up to date. The previous rating awarded by the Care Quality Commission was displayed within the home.