

Voyage 1 Limited Melbreck

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

Melbreck is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Melbreck accommodates up to 26 people with learning disabilities and complex needs in one adapted building. At the time of our inspection there were 24 people living at the service.

This service was set up and registered prior to Building the Right Support and Registering the Right Support and it is not the type or size of service we would be registering if the application to register was made to CQC today. This is because it does not conform to the guidance as it is very difficult for large services for people with learning disabilities to meet the standards.

This inspection took place on 30 October 2018 and was unannounced.

There was a registered manager in post who supported us during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At our inspection on 19 and 25 July 2017 we rated the service 'Requires Improvement' and identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, consent, person-centred care and good governance. At our inspection on 27 March 2018 we found that despite some improvements having been made, the provider had not met the legal requirements in relation to risk management, person-centred care and staffing. We made a recommendation with regards to the governance of the service.

Following both inspections, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective, Caring, Responsive and Well-Led to at least good. At this inspection we found that although further improvements had been made in some areas, there were continued breaches of regulations. These related to the management of risk, healthcare monitoring, family involvement, responding to complaints, record-keeping and good governance.

There were continued risks to people's safe care and well-being as healthcare needs were not consistently monitored. The supervision and competence monitoring of clinical staff was not consistent and effective. The service had not always fully involved families in their loved one's care and complaints were not always recorded. People's care records were not always accurately maintained and quality audits did not always identify shortfalls in the service. There was a lack of support for the registered manager from the provider. The policy review process had negatively impacted on the trust some relatives had in the service.

Sufficient staff were deployed to meet people's needs. Robust recruitment processes were in place to ensure only suitable staff were employed. Staff demonstrated a good understanding of their responsibilities in safeguarding people from potential abuse. Safe medicines processes were in place and staff competence in supporting people in this area was assessed. Accidents and incidents were reviewed and action taken to prevent them happening again. People lived in a safe environment and regular health and safety checks were completed. Staff followed safe infection control procedures. The provider had developed a contingency plan to ensure that people's care would continue to be provided in the event of an emergency.

People were supported by staff who received an induction into the service and regular training. People lived in an environment which was suited to their needs. In some areas of their care people had access to healthcare professionals to support them in maintaining good health. People's nutritional needs were met and people were provided with a choice of healthy foods. People's legal rights were protected as the service was working in line with principles of the Mental Capacity Act 2005.

People were supported by individual staff who showed kindness and care. People's dignity and privacy was respected by staff and people were supported to maintain and develop their independence. Staff had a good understanding of people's communication needs and interacted with people in a positive manner. Visitors were made to feel welcome and there were no restrictions on visiting times. In some areas care records reflected people's needs and end of life care plans were sensitively written. Significant improvements had been made in the activities available to people which had impacted positively on their well-being.

Staff told us they felt supported by the registered manager and were able to speak openly regarding any concerns. There was a good sense of team work and a positive approach from staff. People's opinions of the service were monitored through person-centred reviews and keyworker involvement. The CQC had been notified of significant events in line with regulatory requirements.

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?

Requires Improvement ●

The service was not consistently safe.

Risks to people's safety were not always appropriately monitored and responded to.

Safe medicines processes were followed.

Infection control processes were in place to keep people safe.

Sufficient checks on the premises were completed to ensure people lived in a safe environment.

Staff were aware of their responsibilities in protecting people from the risk of abuse.

There were sufficient staff deployed and recruitment checks were completed to ensure staff employed were suitable to work at the service.

Is the service effective?

Requires Improvement ●

The service was not always effective.□

People's healthcare needs were not always monitored and addressed.

Staff skills were not always adequately monitored.

Systems were in place assess people's need and to ensure they could be met prior to them moving into the service.

Staff received training to support within their roles.

People's nutritional needs were met.

People's rights were protected in line with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Whilst individual staff treated people with kindness, people's individual needs were not always fully considered.

People were treated with kindness and respect.

Staff had developed positive relationships with people.

People's privacy and dignity was respected.

People's independence was promoted.

Is the service responsive?

The service was not always responsive.

Relatives were not always given the opportunity to be fully involved in the family member's care.

Complaints were not always responded to in line with the provider's policy.

Care records were not always fully reflective of people's current needs. In other areas we found there was detailed guidance available to staff to support them in providing people's care well.

People's end of life care plans were completed sensitively.

Activities had significantly improved both within the community and when people were spending time at home.

Requires Improvement 

Is the service well-led?

The service was not well-led.

The provider had not taken robust action to address repeated concerns regarding the safety of people's care.

Systems implemented to monitor people's clinical care had not been effective and quality assurance systems had not identified concerns.

There was a lack of support for the registered manager.

The provider had failed to ensure that policies were developed in line with the needs of the service.

Inadequate 

Melbreck

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 October 2018 and was unannounced. The inspection was carried out by two inspectors and a specialist nursing advisor.

The inspection was prompted by information received from relatives, the local authority and the clinical commissioning group. Concerns related to the way in which risks to people's health and well-being were being monitored and addressed, the consistency of systems in place to monitor health appointments and relative's access to information regarding their family member's care.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As people present during our inspection were unable to fully share their views of the service, we observed the care they received and the interactions they had with staff. We spoke to the registered manager, the clinical support manager for the provider and seven members of staff. Throughout the inspection process we spoke with five relatives regarding the care their family member received.

We reviewed a range of documents about people's care and how the home was managed. We looked at three care plans, medicines administration records, risk assessments, accident and incident records, complaints records, four staff files and internal audits.

Is the service safe?

Our findings

We received mixed views from relatives regarding the safety of the service. Some relatives we spoke with told us they no longer felt their family members were safe living at Melbreck. This was due to incidents where they felt the care they had received was not safe and that their needs had not always been effectively monitored. One relative told us, "I've lost all faith and trust in them being able to care for (name)." Another relative told us, "I'm constantly worried now what's happening. I don't think (name) is safe there anymore." In contrast, other relatives told us they felt their family member were well cared for at Melbreck. One relative told us, "I'm happy with them overall. They've done well by (name)." Another relative said, "Its fine. (Name) absolutely loves it there. They spend a lot of time with her."

At our last inspection in March 2018 we found that risks to people's well-being were not always identified and monitored. At this inspection we found that although some improvements had been made, risks arising from people's specific healthcare needs were not always monitored and concerns acted upon.

Guidance was not always available and correctly followed with regards to people's healthcare needs. We found one person's epilepsy was not appropriately monitored. Records showed that the person's seizures should be recorded on a monitoring chart and should be reviewed by nursing staff. The person's records showed that seizure monitoring was inconsistently completed with no recording completed between June 2018 and September 2018. However, records since this date showed the person experienced regular seizures. Monthly health monitoring reviews for September and October 2018 did not identify or review the seizures the person had been experiencing. The registered manager confirmed that recording had not been completed as it should have been and stated their intention to discuss additional staff observations with the person's relatives.

The person's care records stated that an audio monitor was used to alert staff if the person was having a seizure during the night. However, from the description of the person's seizures, they did not make audible sounds when experiencing seizures. This meant the control measure for keeping the person safe at night was not effective. During our inspection in July 2017 we discussed the effectiveness of the use of audio monitors as a reliable and appropriate measure for monitoring people's epilepsy at night. We were assured at this time this would be looked in to. At this inspection we were told this work was still in progress and specialist epilepsy monitoring devices had been ordered for some people.

The provider had previously informed us the purpose of implementing the monthly health monitoring reviews was to ensure that any appointments or health concerns were closely monitored and followed up on. The provider's PIR stated, 'Each day an individual's health action plan is reviewed for that current month to ensure that they are getting the correct support. This includes ensuring referrals are made, that any follow up is actioned and people attend the relevant clinics and appointments as required to their needs.' However, our analysis of monthly health monitoring reviews for two people showed that key information had not been referred to. This meant there was a risk that staff were not aware of health concerns or that appointments would not be followed up on.

Due to a specific health condition, one person required nursing staff to monitor them on a regular basis for signs of ill-health. However, we found the monitoring chart was not completed at the required intervals which meant staff may not be alerted to the person being unwell. The care plan in place regarding the specific condition did not provide staff with guidance regarding the action staff should take if they found the person was unwell. We asked nursing staff who they should contact should this be the case. They told us they were unsure of the immediate action they should take. This meant the person may not receive the immediate care they would require should they become unwell. This put the person at significant risk of harm. The registered manager ensured that guidance was implemented during our inspection.

Fluid monitoring charts were not always accurately completed and reviewed to ensure people were drinking sufficient amounts. Where people were assessed as being at risk of dehydration, a daily fluid target was written within their care plans. Daily monitoring charts showed that these targets were not consistently met and that people's total fluid intake was not totalled and reviewed on a daily basis. However, we did note that people were offered drinks frequently throughout the day.

Due to people's complex health needs, systems to ensure regular monitoring of people's well-being were required. Whilst processes had been implemented to monitor people during the night, risks when people chose to spend time in their room during the day had not been assessed. No systems for monitoring people's epilepsy or conducting checks at specific intervals had been implemented. This meant that health concerns requiring immediate action may not be identified in a timely manner.

The failure to ensure that risks to people's safety and health were robustly monitored was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas we found that risks to people health and well-being were closely monitored and control measure to minimise risks followed. Care records contained updated risk assessments in areas including mobility, falls skin integrity, nutrition, hydration and epilepsy. Where concerns were identified staff followed guidance to keep people safe. One person's risk assessment showed they were at risk of developing pressure sores. Records showed that staff supported the person to reposition regularly and to spend time on their bed or in a comfortable chair. The person's skin remained healthy. Another person's records showed they were at risk of choking and gave set procedures for staff to follow in order to reduce this risk. We observed the person's food was prepared in line with this guidance and they had access to the specialist crockery and cutlery they required.

Accidents and incidents were recorded and action taken to minimise the risk of them happening again. The provider had an electronic system to monitor accidents and incidents and how these were investigated and acted upon. This enabled the registered manager and the provider's quality team to identify any trends and ensure that appropriate action was taken to minimise risks to people's safety.

Sufficient staff members were deployed to meet people's needs. Staff had time to spend with people in communal areas and people did not have to wait for their care. Staff we spoke with told us they had time to spend with people and did not need to rush people's care. One staff member told us they felt staffing was an area of improvement within the service. They told us, "We concentrate more on a person-centred way of caring, we spend more time with (people) now." Since our last inspection there had been a reduction in the number of agency care staff employed at the service and the majority of shifts were now covered by permanent staff. This had led to an increased consistency in the care people received. The registered manager told us the service was concentrating on the recruitment of nursing staff as the majority of clinical shifts continued to be covered by agency staff. To minimise the risks associated with this, the service had increased the number of clinical hours on each shift to ensure that there were always two nurses on duty

during the day.

Safe recruitment procedures were in place to assess the suitability of prospective staff. Staff recruitment files contained application forms, evidence of face-to-face interviews, references and photographic identification. Prior to starting employment each staff member had undergone a Disclosure and Barring Service (DBS) check. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff we spoke with confirmed they were not permitted to start their employment until all recruitment checks had been completed.

Staff understood their responsibilities in safeguarding people from abuse. Records showed that staff had undertaken safeguarding training and they were able to demonstrate an understanding of the different types of abuse, signs to be aware of and reporting procedures. One staff member told us, "It's good that the manager is so approachable. You know you could report things to her and it would be investigated." Information regarding how to report concerns as a reminder to people, relative and staff was displayed within the service. Records showed that when concerns were raised, these were reported and investigated in line with local authority procedures.

People's medicines were managed safely. Each person had a medicines administration record (MAR) in place which contained an up-to-date photograph along with the name of the person's GP and a list of any known allergies. Guidance was available to staff on how to support people to take their medicines. We observed staff followed appropriate procedures when administering medicines. PRN (as and when required) medicines were correctly recorded and protocols were in place to guide staff in how and when these should be administered. Staff were knowledgeable in the administration of medicines through percutaneous endoscopic gastrostomies (PEG), a tube placed directly into the person's stomach through the abdominal wall. Medicines were securely stored and regular stock checks completed.

People lived in a clean environment and safe infection control practices were followed. Staff had access to personal protective equipment such as gloves and aprons. A cleaning schedule was in place and followed. All areas of the service were clean and well presented. The laundry area had designated areas for clean, dirty and soiled laundry and staff were aware of the correct procedures to follow for soiled items.

People's care and support would not be compromised in the event of an emergency. There was a contingency plan in place which gave guidance to staff on the action they should take and the people they should contact in the event of an emergency. The plan included the provision of alternative accommodation should the building not be safe for use. Fire evacuation drills were completed regularly and personal emergency evacuation plans were in place for each person. These provided guidance to staff and the emergency services on the support people would require to leave the building.

Regular health and safety checks were completed. Records showed that regular servicing of equipment was completed including gas and electrical safety, hoists, call bells and fire equipment. In addition, regular checks of the building were carried out and any maintenance issues were addressed as quickly as possible.

Is the service effective?

Our findings

At our last inspection in March 2018 we identified concerns regarding the support people received in relation to their healthcare needs and the monitoring of clinical staff's skills. At this inspection we found continued concerns in these areas and that the systems implemented to drive improvements had not always been effective.

As reflected in the 'Safe' domain, people's healthcare needs were not always monitored and responded to appropriately. In addition to these concerns we found that there had been delays in appointments being followed up. At our last inspection in March 2017 a family member told us the service had not followed up on a speech and language therapy assessment which provided guidance to staff on how to support their family member to have food tasters. Although the person received their nutrition through a PEG, they enjoyed tasting some foods and reacted positively to this when supported by their relatives. We contacted the service in October 2018 and were informed the service had not followed up on this and the person was only receiving food tasters when their family members visited. Health appointments and progress were difficult to track due to records being held in different places. It was therefore difficult for staff to gain a comprehensive picture of how people's healthcare needs were being managed.

The failure to ensure that people had access to healthcare involvement was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In some areas we found that progress had been made in building links with healthcare services. The service had begun to work with the Community Team for People with Learning Disabilities (CTPLD). This had enabled access to a number of specialist healthcare professionals who were able to support people living at Melbreck. For example, a rheumatologist had recently visited the service to look at people's on-going care and make recommendations going forward. Records showed that people were supported to attend hospital appointments and where people were noted to be unwell, GP appointments were made appropriately. Routine healthcare appointments such as the dentist and opticians were supported and people attended annual health and medicines reviews.

Staff skills were not always effectively monitored, particularly with regards to people's healthcare needs. We spoke with a professional who had contact with the service. They told us that staff did not always understand the reasons why they supported people in a particular way. For example, staff knew that people required thickened drinks where this was written in their care plan. However, they were unable to explain the reasons why this may be required. This meant that staff may not fully understand the risks in relation to people's care. The registered manager told us that, when asked, staff had reported they were unsure if one person's seizures were a result of their epilepsy or if this was a behavioural response to certain circumstances. Staff had not understood the importance of sharing these observations with the clinical team and relevant healthcare professionals prior to the registered manager asking them.

As reported, clinical staff responsible for monitoring people's on-going healthcare had not always demonstrated a skilled approach to record-keeping and care planning in line with their responsibilities.

Records showed that nursing staff had only recently begun to receive supervision. We looked at two nursing staff records which showed each had received one supervision since our last inspection in March 2018. The content of supervisions was generic and was not specifically designed as a clinical supervision. This meant nursing staff had not had the opportunity to review and discuss their professional competence and learning.

The failure to ensure staff had the skills they required to provide care in line with people's needs was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The clinical support manager told us they had recently met with the CTPLD manager to look at additional support which may be available. As a result, they had commissioned the CTPLD to provide induction training to staff working in their services in the local area. The clinical support manager told us they were hopeful the training would be implemented soon.

Staff received training and were able to demonstrate their knowledge and skill in other areas of care they provided. Staff completed training and received regular refreshers in areas including safeguarding, moving and handling, basic life support, health and safety and equality and diversity. When speaking with and observing staff we found they understood and followed the principles relating to the training they received. One staff member told us they had completed diabetes training to help them support someone who had developed the condition. They told us, "If we need any training, we can ask our manager and she will arrange it with head office."

New staff starting at the service had received an induction which included shadowing a more experienced staff member. One staff member told us, "I did shadow quite a lot, as well as doing training and reading policies. It was good to be shown how things should be done." New staff were also required to complete the Care Certificate, a set of agreed standards that health and social care staff should demonstrate in their daily working lives. Staff told us that supervision systems were now in place and they found these useful. One staff member said, "This year I started having supervision. We have team leaders now. They share the supervisions." Another staff member told us, "It's nice to have the time to talk things through. It helps to work things out together."

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 make 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).

The principles of the MCA were followed to protect people's legal rights. Individual care records contained capacity assessments and best interest decisions for areas including consent to care and treatment, medicines, bedrails, finances, the use of wheelchair straps and the flu vaccination. Each person's care records contained a decision-making profile which outlined the best way to support the person to communicate their wishes and choices. This included guidance on how to present the information, how to support the person's understanding and the best time to support the person with the decision-making process. Where people were identified as lacking capacity regarding any restrictions in place, a DoLS application had been submitted to the local authority. Applications contained detailed descriptions of people's needs in order for the local authority to prioritise any urgent authorisations required.

People were provided with a healthy and balanced diet. People's weight was closely monitored by staff and action taken where significant variances were noted. Catering staff were aware of people's nutritional needs and received updated information when people's needs changed. People were offered a choice of meals by the chef taking small portions of each option for people to see and smell. People's reactions were then noted to ascertain their preferences. Staff told us that should people not appear to be enjoying their meal, they would offer them an alternative. People received the support they required to eat their meals. On the whole, staff supported people at their own pace and chatted to people they were with. We did observe one situation where the way in which one person's support could be improved. We informed the registered manager who assured us this would be addressed.

The premises were suitably designed for the people who used the service. A lift was available to ensure people could access all areas of their home. Corridors and doorways were wide which allowed easy access for people using wheelchairs. Bathrooms and shower rooms were adapted to suit people's needs and there was access to a number of communal areas which meant people could spend time in a quieter environment if they wished. Communal areas had a homely feel and contained various comfortable seating areas. There was a rolling programme of decoration. People were able to access extensive grounds which were well-maintained.

Assessment processes were in place to ensure that the service could meet people's needs prior to them moving in. People currently living at the service had been there for a number of years or had lived at other services managed by the provider. However, assessment documentation was available and we were informed that people would be supported to transition into the service by having a series of visits prior to moving in.

Is the service caring?

Our findings

Although some relatives expressed concerns regarding elements of their family member's care, they also told us that on the whole staff members treated people with kindness. This was also reflected in the comments we received from other relatives. One relative told us, "I do think the staff all mean well and they are lovely with (name)." Another relative said, "Staff are really nice around him and very professional. He really likes it there." A third relative told us, "They clearly love her and care for her very well."

We observed examples of individual staff members treating people with kindness. However, as detailed within other areas of the report, we found concerns regarding how people's care was monitored and how families were involved. Until these issues are fully addressed, we will be unable to apply a 'Good' rating to the domain of Caring. Prior to our inspection we were made aware of concerns relating to how one person's dignity was maintained during a hospital admission. These concerns are currently being reviewed by the service and relevant authorities.

Staff knew people well and treated them with kindness. Staff used a gentle approach when supporting people. Staff were heard to compliment people on their appearance, ask how they were feeling and greet them warmly when they returned from activities. When staff needed to transfer people, or move them in their wheelchairs, they communicated effectively with people to ensure they felt comfortable and understood what was happening. For example, a member of staff about to take a person to an activity said, "Hello [person], can I take you to the day centre now?" Another person reacted negatively when one staff member asked them if they wished to go out. The staff member reassured the person and asked them if they would prefer to be supported by someone else. The person indicated another staff member and happily went out with the member of staff they had chosen. Staff were able to describe people's likes and dislikes to us, if they enjoyed music, hearing stories or sensory activities. One staff member was supporting people with hand massages. They reassured one person by saying, "Don't worry (name). I won't do your hands, I know you don't like it." An alternative activity was offered to the person.

People's individual communication needs were understood by staff. Staff told us they were able to understand a lot about how people were, their likes and dislikes through their gestures and facial expressions. One staff member told us, "If someone seems unhappy or upset we will look at what could be bothering them and go through a process of elimination until they're more comfortable." We observed staff interacting and communicating with people in individual ways to suit their needs. Staff ensured they positioned themselves at the same level and encouraged people to make eye contact. Appropriate touch was used such as reassuring people by rubbing the arm or hand. Staff were observed to communicate with people in a positive way, encouraging smiles and laughter and reflecting this back to people. Each person had guidelines regarding effective communication which set out how the person communicated and how staff communicated with them. This gave guidance to staff in understanding the meaning of people's body language, vocal sounds and facial expressions to aid them in understanding people's needs, wishes and choices. One relative told us, "They communicate well with him because they know him so well. They see any problems or if he's not happy." The registered manager told us they were looking to explore how technology could be used to support people's communication. One person had begun to use a tablet device

to support them in communicating with staff.

People's independence was encouraged. We observed people were supported to eat independently and had access to adapted crockery and cutlery. One person used an electric wheelchair which enabled them to move around the service without staff support. The registered manager told us that staff had undergone training with regards to the implementation of active support. This was being introduced into the service to enable people to be involved with daily living skills, such as putting away laundry and cleaning their rooms.

People's dignity was respected and people could spend time in the privacy of their room if they wished. We observed staff supported people with their personal care needs discreetly, ensuring that doors were closed. Staff knocked on doors and announced their arrival when entering people's rooms. Staff told us they understood the importance of covering people as much as possible when supporting them with their personal care. One staff member told us, "I wouldn't like to be exposed so I wouldn't do it to them." Where people or their families had expressed specific cultural needs, these were recorded and known to staff.

There were no restrictions on the times people could receive visitors. All the relatives we spoke with described being made to feel welcome when visiting. Relatives told us that staff always spent time talking to them and discussing their loved one's care. The service newsletter informed visitors that an area of the activities room had been designated as a visitors' room and new furniture purchased. Where it was difficult for relatives to visit or people preferred to go to see their family, this was facilitated by the service.

Is the service responsive?

Our findings

At our previous inspections in July 2017 and March 2018, we found that people did not have access to sufficient community activities in line with their preferences. At this inspection we found significant improvements had been made in this area. However, we identified additional concerns regarding how relatives were involved in their family members' care and how complaints were recorded and responded to.

We spoke with two family members who told us they felt they had been excluded from their family members' care, which had led to a loss of trust in the provider. Both stated that they had been denied access to information regarding their family member due to confidentiality and the provider's on-going review of their policy in relation to General Data Protection Regulation (GDPR). One relative told us, "I'm not a 'trouble Mum'. I want (name) to be happy and safe. I'm leaving (name) in their care but I still need to be involved. Looking at care plans has shown problems in the past so now I don't know what they're trying to hide from us. This has all been so devastating." Both family members had previously been fully involved in supporting their family members to develop their care plans and in supporting them with their healthcare needs.

Following concerns being brought to the attention of CQC regarding the involvement of relatives, we requested to see the provider's policy in relation to this. We were informed that the policy was currently under review. Whilst waiting for policy guidance to be finalised by the provider, both relatives had been informed they were no longer able to view care records for their family members. This had caused considerable distress to the relatives concerned. In addition, relatives told us they were not consistently informed of when health appointments were scheduled in order for them to attend along with their family member. The relatives concerned had made it clear to the provider that they wished to be informed. One relative told us, "It really upsets me that I couldn't be there just to give some reassurance and comfort. I've always been there and (person's name) would have wondered what was happening." Another relative said, "If I'm told about appointments it has been the evening before, which makes it difficult to get the time off work." One relative also told us that not being able to attend recent appointments had led to increased concerns regarding their family member's recommended treatment. They told us, "Often I don't know about appointments until I'm told after the appointment." We spoke with the registered manager regarding these concerns. They told us they were aware of the impact this was having and wanted the concerns addressed quickly. They told us, "It's destroying relationships. It needs to be clarified as soon as possible."

Care records did not always contain up-to date and accurate information relating to people's care. One person's care records stated that all staff working with the person were required to complete a particular type of training designed to support staff in managing escalating behaviours. However, the registered manager confirmed that no one living at Melbreck required this level of support with their behaviours and staff did not receive this training. Another person's care passport and health action plan had not been fully updated to reflect their changing needs following a hospital admission.

The failure to involve relevant persons in decisions relating to people's care or treatment and ensure that care records are up to date and accurate is a breach of Regulation 9 of the Health and Social Care Act 2008

In some areas we found that people's care records contained detailed descriptions of the care they required to meet their needs. Staff were provided with guidance regarding the type of support people required, the approach people preferred and any specific information which would make the person feel more comfortable. Care plans covered areas including personal care, moving and handling, daily routines and nutritional needs. In addition, one-page profiles were completed which gave staff an overview of people's needs, likes, dislikes and social history. Regular person-centred reviews were completed which reflected what was working well for the person and any developments which would improve the person's care. Care records also reflected the care people would prefer when reaching the end of their life. Although no one living at Melbreck was receiving palliative care, guidance regarding their wishes were sensitively recorded.

Complaints were not always acknowledged and responded to in line with the provider's policy. During the course of our inspection we were made aware of a number of concerns which family members had shared with the service. These included the failure to inform relatives of health appointments, incorrect information being shared with health and social care professionals, and concerns regarding how one person was being supported. None of these concerns had been recorded as complaints and as such had not been subject to a systematic investigation. This meant that concerns had not been addressed promptly and complainants had not received a full response to their concerns. We spoke with the registered manager and clinical support manager. They acknowledged the concerns should have been treated as complaints. They told us they would review how concerns were responded to and look to provide additional training to staff in recognising and reporting complaints.

The failure to record and respond to complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to activities in line with their preferences. The provider's PIR stated, 'Each person has a personalised activity plan which is based on the activities they enjoy. We promote people to access the community and take part in activities that they enjoy such as going to the cinema, shopping and eating out. Some people attend external day centres and enjoy taking part in music workshops.' We found that significant improvements had been made to the activities available to people which had had a positive impact on people's lives. This was particularly evident in the increased access people had to community based activities.

People's records showed they were now getting out more and the range of activities available was continuing to develop. People were now taking part in activities such as sailing, outdoor pursuits, cinema visits and shopping. People had also started to attend a number of different sessions at an activity centre in the local area which included crafts, drama and music. The registered manager told us they were now looking at developing evening activities and had planned theatre trips, music events and evening shopping trips. People were continuing to attend the resource centre run by the provider and one person told us they were about to start work experience in the catering department each week. They were clearly looking forward to this and eager to start. Staff told us they felt the increased number of community activities had been a positive development in the service. One staff member told us, "People are doing more since (registered manager) came. There was no time for activities before. Before was too much rush, now we have more time." Another staff member said, "Having more activities is better for all of us. Staff are really motivated to get people doing things now."

In addition, activities were provided for people when staying at home. During the inspection we observed people taking part in music sessions, sensory activities and receiving hand and foot massages. A gardening

group had proved successful in the summer with home-grown vegetables being produced. The registered manager also arranged activities providers to visit the service to provide sessions including music, cookery and indoor golf.

Is the service well-led?

Our findings

At our last inspection in March 2018 we found that although there were repeated concerns and breaches of regulations, the management team and provider were taking steps to improve the service. The provider told us that people's health care needs would be more closely monitored and that a number of systems were being implemented to ensure that people's healthcare needs were responded to in a safe and effective way. At this inspection we found that the systems planned had not been effective in ensuring people's health needs were monitored. In addition, we found that audits were not ensuring improvements in quality in a number of areas and that there was a lack of support for the registered manager in monitoring people's clinical needs.

The service has been in breach of regulations regarding people's safe care and treatment for the past three inspections conducted at the service. During this time there have been a number of concerns raised by families and health and social care professionals relating to how people's healthcare needs have been monitored and acted upon. At our last inspection the clinical support manager for the provider told us they recognised the need to monitor the quality of the support people received to monitor their clinical needs. As a result, they had agreed to develop and conduct a clinical audit themselves whilst awaiting the quality team devising a suitable quality assurance tool for this area. In addition, they told us they would ensure regular clinical meetings and supervisions for staff working at the service and that they were in the process of changing nursing recording systems.

At this inspection we found that these systems had not been fully implemented and had not led to sustained improvements. Only one clinical audit had been completed which had not identified concerns regarding how people's health care needs were being monitored. We were informed the service were still awaiting the quality team developing an appropriate tool for this area of people's care. The generic audit tool used by both the operational and quality team had failed to identify the concerns regarding people's care despite the increased focus on this area from external services. The provider's PIR stated, 'Quality assurance systems are robust and

work well in identifying areas for improvements which are then transferred onto a consolidated action plan for implementation and review.' We found that quality assurance measures had not been effective in identifying concerns. Changes made to the nurses' recording systems had not been used effectively. This had led to information being difficult to access and recorded in a number of different places. Clinical meetings had been held although these were chaired by the registered manager, who was not clinically trained. There was no evidence to demonstrate these meetings had led to improvements in clinical practice within the service. As reported nursing staff had not received consistent clinical supervision to monitor their skills.

Whilst the registered manager and clinical support manager acknowledged that people's health needs were the responsibility of all staff, they had not implemented any monitoring systems to support and provide additional training to care staff. The CTPLD had offered to support the service in the training and mentoring of staff earlier in the year. The service had informed them they did not feel it was the right time to accept this support. The clinical support manager told us that at the time the staff team were deflated and there had

been a number of changes in the service structure and additional training. They had therefore wanted to ensure this was embedded into practice before adding the additional pressure of new training. However, we found this meant there had been a delay in care staff understanding their responsibilities in supporting people with their healthcare needs. The clinical support manager told us they had recently met with CTPLD and agreed a way to work together to provide staff with the training they required. This would be rolled out to all staff and not limited to nursing staff.

There was a lack of support for the registered manager, particularly in relation to managing people's clinical needs. The registered manager was not clinically trained and the service had struggled to recruit and retain a clinical lead/deputy manager for the service. This meant the registered manager had responsibility for managing the nursing team without having the qualifications required. Support had been provided on occasions from a clinically-trained manager although this did not replace support with day-to-day management tasks and in-depth clinical knowledge of the people living at Melbreck. A clinical lead had recently been appointed at the service and had previous knowledge of the service. The registered manager was confident they would work well together in addressing concerns.

There was a lack of understanding regarding the impact of delays in implementing the revised policy regarding relatives' involvement in people's care. Families had been told that due to changes in legislation regarding General Data Protection Regulation (GDPR) they were no longer able to access records in the same manner and that the provider was in the process of devising a policy to address this. However, GDPR came into operation in May 2018 and required organisations to have systems in place from that date. When the concerns of family members became clear, the provider had failed to act quickly to minimise the impact of the decisions made. From our discussions with the registered manager and clinical support manager it was apparent there was confusion regarding the rights of relatives to be involved in the planning and review of their family members' care and what legislation and guidance covered this.

There had been no relatives' meetings held at Melbreck since August 2017. This meant relatives did not have a forum for discussing any specific concerns or positive changes. When speaking to families we found a common theme of relatives saying they did not know what other relatives thought of the service. Relatives told us they would value the opportunity to meet other families and to support the service through relatives' meetings.

The failure to ensure good governance of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they enjoyed the social events organised by the service such as the Christmas party. The registered manager told us that they were in the process of compiling a newsletter which they forwarded to us following our inspection. This gave families an overview of what people had been doing and any developments in the service.

Staff told us they felt there was a positive culture amongst the staff team and that staff wanted to provide good care for people. One staff member told us, "It's a really nice team. Staff want to do a lot for people. It's like a second home really." Monthly staff meetings were held which gave staff the opportunity to receive updates regarding developments in the service and the organisation. Staff told us they were able to discuss things openly within the meetings and felt their views were listened to. One staff member told us, "We are free to speak out and raise concerns. The manager has things to share with us and we can share things with her."

Discussions also included any concerns, people's individual needs and any specific events. Staff told us the registered manager was approachable and supportive. One staff member told us, "If I have a problem, I will go to her."

Due to people's complex communication needs, people's views of the service were gathered in a variety of ways including having a keyworker system. The keyworker was responsible for working with each individual to develop activities and choices with them. In addition, the person-centred review process enabled ideas to be shared regarding how people's support could be developed. Annual surveys were sent to relatives and others involved in the service. There had been no surveys completed since our last inspection of the service.

People's confidential records were stored securely. The CQC had been notified of all significant events that happened in the service in a timely way. This meant we were able to check that the provider took appropriate action when necessary.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to ensure that people had access to healthcare involvement, that relevant persons were involved in decisions relating to people's care or treatment and to ensure that care records are up to date and accurate

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider had failed to consistently record and respond to complaints

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had failed to ensure staff had the skills they required to provide care in line with people's needs

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure that risks to people's safety and health were robustly monitored

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure good governance

The enforcement action we took:

Warning notice issued