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Melrose Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

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. 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 30 June and 10 July 2017. At that time we found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to; requirements relating to registered managers; person centred care; dignity and respect; need for consent; safe care and treatment; safeguarding service users from abuse and improper treatment; good governance and fit and proper persons employed. We also found a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009 in relation to notifications of other incidents. Due to these failings an overall rating of 'Inadequate' was awarded at that time and therefore the home was placed in 'special measures'. This means that the service was kept under review, and would be inspected again within six months of the inspection report being published.

Following the last inspection, we met with the provider to confirm what they would do and by when, in order to improve all five key questions to at least good. Due to the significant on-going failings of this service we also served a notice of proposal to cancel the registered manager's registration. Representations received from the registered manager were not upheld.

This inspection was unannounced, which meant that people did not know we were going to visit the home and it was conducted by two adult social care inspectors from the Care Quality Commission.

This inspection was undertaken on 27 and 28 February 2018. The new manager was on duty at the time of our inspection. She had been in post for four months and was in the process of applying to the Care Quality Commission to become the registered manager of Melrose Residential Home. 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 three continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care; safe care and treatment and good governance.

We were told by the manager that no-one who lived at the home was being deprived of their liberty. 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 made a recommendation about this. Staff we spoke with had little knowledge around the area of advocacy. We made a recommendation about this.

We found risks to people's health and safety had not always been identified and mitigated, in order to keep people safe from harm. There were also some minor safety issues noted during our tour of the premises.

We found infection control practices were better, although some areas were still in need of improvement. The environment was clean and hygienic throughout, except for the catering facilities, which were in need of a thorough clean.

We found the management of medicines to be poor. This put people at risk of harm, due to unsafe medicine practices.

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 found people who lived at the home were treated with respect and their privacy and dignity was consistently promoted.

We assessed the systems for monitoring the quality of service provided. We found the quality monitoring, governance and oversight systems had improved since our last inspection, although further improvements were still needed.

We looked at the personnel records of three staff members who were employed at Melrose. We found that recruitment practices adopted by the home were satisfactory. All relevant checks had been conducted and required documentation obtained. This helped to ensure that new employees were deemed fit to work with vulnerable people.We found some improvements had been made and the new manager was working towards a more structured approach around staff support mechanisms. We made a recommendation about this.

We found the home had shared appropriate information with the relevant authorities and statutory notifications had been submitted to the Care Quality Commission.

A new manager had been appointed, who had made some progress. However, further improvements were still needed.

At this inspection we found the environment to be warm throughout. However, the premises were in need of updating and modernising, as the environment was looking tired and worn. We made a recommendation about this.

People looked happy and comfortable in the presence of staff.

Meals looked appetising and were well presented, although the atmosphere was not conducive to an enjoyable dining experience. We made a recommendation about this.

We found that systems and equipment had in general been serviced in accordance with the manufacturer's recommendations, to ensure they were fit for use, although there was no record available to show the hoist slings had been appropriately serviced. However, we were told the hoists were not being used by those who currently lived at the home.

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. People 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 the last inspection the overall rating for this service was 'Inadequate' and the service was therefore placed in 'special measures'.

At this inspection we found some improvements had been made. However, although the overall rating is now 'requires improvement', the domain of 'safe' remains 'inadequate'. Therefore, the 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

Medicines were not being well managed and risks to people's health, safety and wellbeing were not appropriately assessed.

Staff members were aware of safeguarding procedures and had received recent training in this area. Systems and most equipment within the home had been serviced in accordance with the manufacturers' recommendations.

The control of infection could have been better in the kitchen and fire safety practices did not always protect people from potential harm.

Recruitment practices adopted by the home were robust. This helped to ensure that only suitable staff were appointed to work with vulnerable people.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Records showed that new staff had completed induction programmes and progress was being made towards structured regular supervision and annual appraisals.

Training for the staff team had improved, but this could have been improved further.

The principals of the Mental Capacity Act 2005 had not been fully implemented. However, consent had been obtained, in relation to care and support.

The home was comfortable and meals looked appetising.

Is the service caring?

Good

This service was 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.

Those who lived at the home were supported to maintain their independence, as far as possible and staff members communicated well with those in their care.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

Although pre-admission assessments had been conducted the planning of people's care was not always person-centred. People's assessed needs had not always been transferred to the plans of care.

People were offered some 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?

Requires Improvement

This service was not consistently well-led

Although some improvements were noted 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 were 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 27 February 2018 and was unannounced. It was conducted by two Adult Social Care inspectors from the Care Quality Commission (CQC). At the time of our inspection there were 12 people who lived at Melrose. We spoke with six of them and two family members.

We spoke with four members of staff, the manager of the home and the provider. We toured the premises, viewing a selection of private accommodation with permission and all the communal areas. We observed the day-to-day activity within the home and we also looked at a wide range of records, including the care files of four people who used the service. This enabled us to determine if people received the care and support they needed and if any risks to people's health and safety were being appropriately managed.

We also looked at the personnel records of two 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, such as deaths, serious injuries and allegations of abuse. We also looked at information we had received from other sources, such as the local authority and community professionals involved in the care and support of those who lived at the home. We did not request a Provider Information Return (PIR) on this occasion, as the provider had completed one six months previously. A PIR is a document which provides us with key information and data about the service, including improvements they plan to make. 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 am most certainly safe here. The girls see to that. They wouldn't let anything happen to us" and "I feel safe here. We are looked after very well."

At the last inspection we found processes had not been implemented to ensure that risks to the health and safety of people were identified and reasonably mitigated. At this inspection we found assessments did not always identify areas of risk and did not include individual strategies in order to protect people from harm.

There were no environmental risk assessments in place to ensure the premises were maintained to a good standard, in order to keep people safe. On the first day of this inspection we toured the premises and found the home to be, in general safe for people who lived at Melrose. However, we noted some minor improvements were needed. For example, a raised toilet seat was not secure in one en-suite bathroom, the pedal bin in another bathroom was located on a ledge raised off the floor and should someone attempted to operate the foot lever they could have been injured. There were several picture hooks in the walls of one bedroom without pictures, which were dangerous and unsightly.

We looked at the care files of four people who lived at Melrose and found several assessments had been introduced within a risk management framework. However, these were found to be very generic in nature and some areas of risk had not been sufficiently considered. For example, the risk was identified followed by a list of generic recommendations, such as 'Consider how the service user can be observed/supervised more easily.' The answer alongside this recommendation stated, 'Observed by staff especially when not well.' A falls risk assessment had been conducted for one person, who did not have a history of falls. This was a standard form, which stated 'All older women are likely to get osteoporosis.' This did not promote person centred care or support.

We observed one person who was eating lunch in the dining room to be coughing excessively. There were no staff members in the vicinity to assist, so one of the inspectors went to support the individual. This person said that they had been troubled for a long time with coughing when they ate food. We asked if they had seen any health care professional about their condition. They told us they had not.

We looked at the care records of this person. The pre-admission assessment showed a small diet was required. The care plan, dated 17 July 2017 stated this person could eat independently, but required assistance with pouring drinks and needed food to be cut into small bite size pieces. A nutritional profile, dated 20 July 2017 did not identify these areas, except for help required to pour out drinks. This profile asked; Do you require any measures to help with swallowing? The answer to which was 'no'. However, incident records showed this person had experienced a choking episode on 20 November 2017, when a piece of meat had lodged in their throat. Despite the care worker responding appropriately on this occasion, there was no risk assessment or care plan in place in relation to episodes of coughing spasms when eating and drinking or the risk of choking. The daily record stated that this person ate a 'normal' diet. There was no evidence available to demonstrate that advice had been sought from health care professionals, such as

Speech and Language Therapist (SALT) or dietician. The nutritional profile for this person indicated a dietetic referral should have been considered. However, there was no evidence available to show this had been done. Therefore, this person was potentially at risk of choking. This was discussed with the senior care assistant at the time of our inspection, who confirmed she would address these matters of concern. The manager has since told us that advice has been sought from the SALT team and meat for this person is now being blended in order to reduce the possibility of choking and coughing episodes. The SALT team will review the individual again in due course.

The care records for another person showed they had last been weighed two months prior to our inspection and despite a loss of weight, which was attributed to diuretic medication; they had not been weighed since. We asked if there were any other weight records within the home. We were told there were not. The nutritional profile and weight plan of care for this individual did not record their particular liking of snacks or any dietary likes and dislikes. This record had last been reviewed in September 2017 and it stated, 'To monitor weight monthly'. Therefore, this care plan had not been reviewed and updated since they had lost weight in December 2017.

A pressure area risk assessment had been conducted for one person, which showed a medium risk of tissue damage. This had not been reviewed and updated for four weeks, despite the body map for this individual showing areas at risk of breakdown. There was no care plan in place pertaining to the risk of tissue damage and therefore no guidance for staff around appropriate pressure care or the use of specialised pressure relieving equipment.

We noted that on one occasion instructions from a specialist health care professional had not been followed in day to day practice. The records of another person whose care we pathway tracked showed that on 15 February 2018 a health care professional instructed staff to weigh the person every week, but this direction was not being followed in day to day practice. This could have had a detrimental effect on the well-being of these two people.

We looked at the accident and incident records. These showed one person had fallen five times during January 2018. These falls were all un-witnessed. None were recorded on the falls diary and there was no reference to falling in the plan of care. One of the falls resulted in hospital admission. The falls risk assessment, dated 15 February 2018 was found to be generic and not person centred. For example, this record showed the person had fallen more than once in the past twelve months, but these were not detailed. The actions identified as 'must be completed' had not all been addressed and a referral had not been made to the falls team. Therefore, the falls risk management tool was not effective. The general risk assessment for this person was not dated, but stated they were at low risk of falls and it was written, '(Name) is at low risk of falling, as (name) is independent.' This information was inaccurate and could have potentially placed the individual at risk of harm. The senior care assistant told us she would make a falls referral without delay.

A fire procedure was in place and a fire risk assessment had been developed in conjunction with an independent fire safety specialist, following their inspection of the home in August 2017. This resulted in six areas being identified as high priority, which meant that action was required as soon as was reasonably practicable.

The action plan we saw did not demonstrate that any work had been completed. We asked the provider about this, who told us work had been done, as required, although it had not been recorded on the action plan at the home. We asked the provider to update the action plan. The provider indicated on the action plan that a self-closing mechanism had been purchased for the upper fire door on the basement stairwell,

but that this had not yet been fitted. This work needed to be done as a matter of urgency. The provider also documented on the action plan that the fire alarm detection system was being tested weekly and that the emergency lights were being tested each month. A notice displayed in the home showed that a weekly fire alarm test was to be conducted every Monday morning at 9am. There was no record of this being done and there was no recorded test for the emergency lights. Therefore, there was no evidence available on the day of our inspection to demonstrate that the provider had addressed all areas identified as a high priority. This put people at risk of harm. Lancashire fire and rescue service visited the home on 9 January 2018, in order to evaluate the fire safety provided. The letter addressed to the manager from Lancashire fire and rescue service stated, 'I am of the opinion that some people are at risk in case of fire. You have reassured me that you will make the necessary improvements. You have an on-going duty to ensure the safety of people.'

The schedule of work needed to keep people safe included; testing of the fire alarm, to incorporate automatic door closures, automatic ventilation systems and electronic door lock releases; testing of emergency lighting, to ensure that escape routes can be safely used whenever they are needed; to carry out fire drills, so that people understand what they need to do, should fire break out and to add a device to the front door, which releases on activation of the fire alarm. Some of this work, such as testing of the fire alarm system and emergency lights had been identified during the visit by an independent contractor in November 2017 and although the provider stated this work was on-going, there was no record to show it was being completed. Lancashire fire and rescue service later identified some of the same issues in January 2018 and we found these still to be outstanding during our inspection on 27 and 28 February 2018.

The PEEPs [Personal Emergency Evacuation Plans] needed to be improved. Those we saw contained inaccurate information, as they referred to a 'grab box', which we established was not available within the home and guidance for staff in relation to horizontal evacuation was not evident. We discussed this with the manager at the time of our inspection, as each group of people who lived at the home had been identified by a colour, in accordance with their level of dependency. A 'stay in place' policy had been introduced, which indicated that the 'blue' group were to stay in place in the event of a fire, as this was supported by self-closing doors. However, we were concerned should someone be identified to stay in place, despite being closest to a fire. Information documented on the PEEP records also needed to provide more specific details about each individual. For example, we had identified two people who had communication difficulties and another who could become anxious, but this information was not recorded on the PEEPs and therefore emergency services would not be aware of the specific needs of these people.

Our findings above resulted in a continued breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At the last inspection we found that medicines were not being managed safely. During the course of this inspection we assessed the management of medicines and found this area had not improved. The failings we found put people at risk of unsafe medicine practices.

We looked at the Medication Administration Records (MARs) of seven people who lived at the home. We found these contained any allergy information and photographs of individuals for identification purposes. This helped to reduce the possibility of medicines being given to the wrong person. Five of these people were prescribed 'as and when required' (PRN) medicines, but the protocols in place for four of them were very basic and did not provide staff with clear guidance of when these medicines should be given. The protocols simply stated, 'for pain', which was not sufficiently detailed and when these were administered, the reason for this was insufficiently detailed, as it recorded either, 'given' or 'refused'. Specific care plans had not been drawn up to support the administration of PRN medications. The systems used for the application of creams were not sufficient and did not promote safe medicine practices. We asked for the

previous MAR charts of one particular person we were pathway tracking. The senior carer worker told us there records 'are in a mess and need rewriting'. We asked to see them and found them to be poorly completed.

Weekly and monthly medication audits were being conducted. The audit for September 2017 stated, 'Gaps in MARs still an issue and topical cream still an issue.' However, action plans had not been developed as a result of these findings and although more recent audits were evident these did not indicate if the previous shortfalls had been sufficiently resolved. Our findings at the time of this inspection highlighted very similar issues and therefore the auditing system of the medicines was not entirely effective. We noted that some medicines, such as liquids and eye drops had expired their shelf life and therefore could have been ineffective. These needed to be replaced as soon as possible.

Some protocols which were in place, such as the safe handling of medicines and the protocol for Controlled Drugs showed they needed to be reviewed in 2016, but this had not been completed.

Handwritten entries on the MAR charts had not been signed, witnessed and countersigned in order to reduce the possibility of transcription errors and one MAR chart we saw for ear drops stated, 'Five drops to be used in the affected ear twice a day'. This was insufficient information, as it was not clear which ear was affected, or if both ears required treatment. Prescribed creams for local application did not identify the part of the body these needed to be applied to, but just stated, 'use as needed'. This did not provide staff with clear guidance about the use of creams.

Four MAR charts contained gaps, with missing signatures and reasons for omissions were not recorded. The MAR chart for one person contained an unsigned hand written entry for Codeine Phosphate 30mgs to be taken four times a day. This prescribed medicine had only been given once a day for a period of twelve days. It was not possible to determine which month this MAR chart covered, as the start date had been omitted. Therefore, medicines were not always being administered as prescribed.

We observed a medicine round being conducted and although we found the senior carer to promote a dignified and respectful process, we found that safe practices in administering medication were not embedded into the routines of the home. None of the medicines we saw administered were signed for at the time of them being given to people. We found the medicines of three people were pre-potted into medicine containers. One medicine pot contained six tablets, another four tablets and a third eight tablets. The senior care worker responsible for the administration of medicines confirmed this was normal practice for her. This indicated inherent practice and must be discontinued, as it puts people at serious risk of harm.

The MAR charts for variable dose prescriptions, such as co-codamol, which stated one or two tablets to be given four times a day, but no more than eight in 24 hours, did not always indicate the amount given on each occasion and therefore there was no record of how many tablets had been taken within a 24 hour period. This could have potentially resulted in unsafe medicine practices.

One person had two MAR charts running side by side with the same treatment prescribed. It was difficult to establish which one was being used, as both were being signed. Also two prescribed medicines for this person had not been signed, indicating they had not been given as prescribed. The senior care worker told us they had been refused by the individual. However, this was not indicated on the MAR chart by the use of the associated key and there was no record retained to show refusal of medicines.

One person whose MAR chart we looked at was self-medicating and therefore managed their own medicines. This promoted independence and choice. However, records we saw provided some conflicting

information, as their 'This is me record' stated, 'How I take my medication. Tablets are given by carers and I take responsibility to use my inhaler once in the morning and I take my senna at 20.15', but their care plan stated, 'I administer most of my medication myself' and their MAR chart supported this with a record of the medicines the person self-administered. Although consent had been obtained from the individual themselves, it was not clear which medicines they had consented to administer without staff support. This person's care records showed they could become very depressed and could refuse their medication. However, although a record was available to show action staff needed to take to ensure the person took their medication a risk assessment for self-administration of medicines had not been completed and there was no assessment to show that the individual had been deemed competent to self-administer their own medicines. This did not promote safe medicine practices.

The training matrix showed that seven members of care staff had completed medication competency assessments during the previous twelve months. However, these were not always effective, due to the shortfalls we found around the safe management of medicines.

We noted there to be a variety medication policies and procedures in place at the home and a range of information available for staff around the management of medicines. However, the British National Formulary (BNF) was out of date. A BNF is a manual which provides up to date information about all approved medicines and this is updated annually.

The amount of medicines received into the home was recorded on the MAR charts. This enabled a clear audit of prescribed medicines. However, the last medication count was recorded on 14 November 2017.

Medicines for return to the pharmacy department, because they were no longer required had been managed well. Fridge temperatures had been recorded each day, although guidance for maximum and minimum recordings was not available and therefore not monitored.

This resulted in a continued breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medicines.

We observed the senior care worker to be wearing gloves during the administration of medicines, which promoted good practices and people were asked for their consent before medicines were administered. This helped to ensure they were involved in the management of their medicines.

MAR charts showed which local applications were flammable and therefore easily ignited by a naked flame. This helped to protect people from injury or death. Other contra-indications were also recorded on the MAR charts, such as the avoidance of particular foods whilst taking certain prescribed medicines and also when it was necessary to take with or after food.

We checked a random sample of Controlled Drugs (CDs) and found these to be stored securely. The counts were correct with weekly audits in place. This helped to ensure CDs were being managed appropriately.

At the last inspection we found that infection control practices were not robust. At this inspection we found infection control practices were better, although some areas were still in need of improvement.

We were informed by the manager that the Environmental Health Officer (EHO) had been out to the home and had not raised any concerns. However, we visited the kitchen, which appeared to be in need of a deep clean, as it seemed dirty and some equipment was in a poor condition and in need of replacing. Food in the fridge had not been dated on opening and we noted raw meet being stored on the shelving above

uncovered salad. During our inspection we observed two members of staff entering the kitchen without wearing protective clothing. The protective aprons were not easily accessible for staff members. We were told that staff only wear protective clothing when cooking food. This routine did not promote good infection control practices. Therefore, infection control practices were not sufficient in this area of the home at the time of this inspection. We saw an infection control audit had been conducted in September 2017. However, this did not include the catering facilities. We discussed our findings with the EHO, who confirmed they had visited previously with no concerns and had revisited the home following our inspection. The home has subsequently informed us that the EHO has awarded Melrose a rating of 5 for food hygiene, which is the highest level achievable. We have confirmed this with the EHO.

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, such as a gas leak, power failure, flood or utility disruption. However, this was dated May 2015 and was due for review in 2016. This had not been completed and the information provided was out of date, as the recorded data did not correspond with the current situation at the home. It is recommended the business continuity plan be revised, in order to provide accurate information for the staff team.

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. However, we found the hoist slings had not been serviced. Therefore, these had not been deemed safe for use. We were told there was no-one who lived at the home, who currently used the hoists for transferring. The hoist slings need to be serviced before use.

A written policy in relation to safeguarding vulnerable people was in place at Melrose, which was in line with local safeguarding procedures. A member of staff had been appointed as the safeguarding champion, so that any changes in legislation or good practice guidelines could be disseminated amongst the staff team.

At the time of our inspection there were 19 staff employed at Melrose, 11 of who had completed training in safeguarding vulnerable adults within the last 12 months. Staff members we spoke with had good knowledge of the signs and symptoms of abuse. They were aware of safeguarding procedures and were confident in making referrals to the relevant organisations, should this be needed. From our observations it was clear that anti-discriminatory practices were promoted and people's human rights were being respected.

At the last inspection we found that recruitment processes adopted by the home were not sufficiently robust to ensure new staff were fit to work with vulnerable people. At this inspection we looked at the personnel records of three staff members who were employed at Melrose. We found that recruitment practices adopted by the home were satisfactory. All relevant checks had been conducted and required documentation obtained. This helped to ensure that new employees were deemed fit to work with vulnerable people.

Staff members we spoke with told us they were happy with the current staffing levels and felt that the care provided for those who lived at the home was consistent, as little agency staff were used. However, the manager told us she covered some shortfalls in staffing levels due to last minute absences and she had covered the night duty prior to our inspection, due to staff sickness. The manager also told us that she was recruiting some bank staff, so that shortfalls in staffing levels could be covered by a regular staff team and this would enable her to concentrate on managerial duties. The duty rotas we saw confirmed the numbers of staff on duty were sufficient to meet the current needs of those who lived at the home.

Requires Improvement

Is the service effective?

Our findings

All the people we spoke with who lived at the home said they felt confident that the staff had the skills needed to support them. They were also complimentary about the food served. One person commented, "The food is very good. They [staff] ask us what we want." Another told us, "The food is smashing. Very nicely cooked."

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 assessments had not always been conducted to determine if people lacked capacity to make decisions and lawful authority had not always been sought to deprive someone of their liberty.

At this inspection we found some Mental Capacity Assessments had been conducted. However, we saw that one person suffered from short term memory loss and had been diagnosed with vascular dementia. Despite an impairment of the mind or brain, this individual had no capacity assessment on their care file.

Two care files we looked at recorded that a Lasting Power of Attorney (LPA) had been appointed for the person in relation to health and welfare. However, there was no legal documentation available to confirm this appointment. Whilst we saw that one of these people still had the capacity to make some decisions for themselves, there were no copies of LPA's or checks with the Office of the Public Guardian (OPG) to ensure the appointment was valid, so that consent could be given by the appointee when required. We recommend that the provider obtains legal documentation to verify LPA appointments and follows the Mental Capacity Act 2005 guidance in relation to obtaining valid consent.

Records showed the staff team had recently completed training in relation to the MCA and DoLS and staff members we spoke with demonstrated a basic knowledge of these specific areas of care. The manager of the home told us that no-one who lived at Melrose was being deprived of their liberty and therefore applications to the local authority were not required.

At the last inspection we found the provider had not ensured consent to care and treatment had always

been sought from people who were assessed as having the capacity to make decisions. At this inspection we found consent had been obtained from those who lived at the home about their care and treatment. Therefore, the previous breach of regulation had been met on this occasion.

At the last inspection we found that staff members were not supported through robust induction programmes, frequent supervision, annual appraisals and regular mandatory training modules. At this inspection we found some improvements had been made and the new manager was working towards a more structured approach around staff support mechanisms. Therefore, the previous breach of regulation had been met on this occasion.

During the course of our inspection we looked at the personnel records of three staff members. We found induction records to be present on each of the files, which were in line with the common induction standards for social care workers. This helped to make sure new employees were provided with all the information they required to do the job for which they had been appointed. Staff members we spoke with told us that regular supervision sessions and annual appraisals were being addressed by the new manager and were being planned for during the forthcoming year.

We were provided with a copy of the staff training matrix, which showed that a total of 19 staff were appointed at Melrose. We noted that within the last twelve months a good percentage of staff had completed training in moving and handling, fire safety and safeguarding vulnerable adults. The manager told us that the staff team had also recently completed training around MCA and DoLS, falls awareness and end of life care, but that these modules had not yet been uploaded on to the staff training matrix. One care worker told us that training for staff had improved since the new manager was appointed and further training had been planned.

The staff training matrix showed that no staff members had completed training around infection prevention and control, diabetes and dementia care. On the day of our inspection we established the cook was on annual leave and a senior care assistant was responsible for the preparation and cooking of the meals for the week. However, the staff training matrix showed that this person had not completed food hygiene training, as this had only been completed by the two cooks, despite care staff also being involved in the preparation and serving of food and beverages. The senior care assistant told us she had completed the relevant training on line, but could not remember when this was, except it was not during the last year. First aid training had been completed in 2015 by six members of the staff team. Therefore this module was due for updating, to ensure a qualified first aider was on duty on each shift. It is recommended that progress continues to be made towards a structured mechanism for staff support through regular supervision sessions, annual appraisals and mandatory learning modules.

During the course of our inspection we toured the premises and found that although the building was warm and homely, it was in need of updating and modernising throughout. The home was dated and tired looking. There was no evidence available of on-going upgrading to the environment. It is recommended that attention is given to the environment, in order to improve the surroundings for those who live at the home.

We observed the lunch time meal. This was not particularly conducive to an enjoyable dining experience. One member of staff had limited conversation with people. There was a period when the dining room was void of staff. There were no discussions or background music.

People's dietary preferences were recorded in care files. We saw people being offered a variety of choices throughout the day and we observed the meal service at lunch time. The dining tables were pleasantly set with tea and coffee being available for people to help themselves. The menu was designed to cover a four

week rotational period, so that a variety of meal choices was available. There was no reference in relation to choices for the lunch time meal and no option for a vegetarian meal. However, people we spoke with confirmed they were offered meal choices and were able to select alternatives, if they did not want what was on the menu. The food served looked appetising and people told us it was enjoyable.

It was pleasing to see two people dining together in a bay window in the small lounge. They told us they always had their meals at this dining table and were quite content to 'watch the passing show.' One of these people said, "I just have a small portion because I have a big bowl of porridge in the mornings."

The internal temperatures of the fridges had not been consistently recorded and when they had the temperatures were not always below the recommended temperature of 8◦C.

It is recommended that a more conducive dining experience is provided for those who live at the home and that fridge temperatures are recorded daily, with actions to address insufficient temperatures being evident.

Good

Is the service caring?

Our findings

Everyone we spoke with was positive about the care they received and the attitude of the staff team. One person told us, "I went to the doctor's yesterday. Someone came with me in a taxi." Another commented, "They always ring the doctor if I am not well."

At the last inspection we found that people were not always treated with dignity and respect. At this inspection we found people who lived at the home were treated equally and with respect. Their privacy and dignity was consistently promoted.

During the course of our inspection we noted people appeared relaxed in their surroundings and comfortable in the presence of staff members.

We observed staff interacting with people in a pleasant manner. The staff members who were on duty had a lovely kind and caring approach towards those who lived at the home. The senior care worker was particularly compassionate towards those who lived at Melrose. She demonstrated a genuine caring approach towards people.

We saw staff members knocking on people's bedroom doors before entering. The plans of care showed that privacy and dignity was consistently promoted, particularly during the provision of personal care and that people were supported to be as independent as they wished.

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. However, staff we spoke with had little knowledge around the area of advocacy. It is recommended that the staff team be provided with specific training in relation to the use of advocacy, should this be required.

We observed staff members transferring people and helping them to mobilise on several occasions. These manoeuvres were always conducted in a safe and competent manner, whilst good explanations were provided to the individual being assisted, with reassurance, encouragement and praise being offered throughout. Although there was not much communication around lunch time, when we did see staff chatting with people, it was done in a kind and caring way.

One person who worked at the home told us, "I love it here. The residents are absolutely fantastic. I always treat them how I would want to be treated. This is their home."

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with told us, "I never have any complaints, but if I did want to make a complaint I would talk to [manager's name]." At the last inspection we found the provider had not ensured that the care planning process always accurately reflected people's needs and was always person centred.

At this inspection 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 could have potentially received inappropriate or unsafe care and treatment.

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. However, the pre-admission assessment for one person was dated September 2017, despite them being admitted to the home in 2009. The funding authority had also provided detailed assessment of people's needs. This helped the staff team to make sure they had the skills, knowledge and expertise to provide the care and support people needed.

Some good descriptive information was recorded in the care files we looked at such as, 'Things that are important to me', 'What people like and admire about me' and 'How best to support me'. However, although the plans of care were reviewed and updated regularly, they did not always accurately reflect people's current needs and some areas of potential risk had not always been thoroughly assessed. Records we saw did however outline people's preferences and what they liked to do, including their past hobbies and interests.

One person whose care and support we pathway tracked had limited English vocabulary, as English was not their native tongue. The plan of care for hearing and communication stated, 'Staff to collate key phrases and gestures for my own communication passport. Update when required.' This had not been completed. There was no communication passport in place. However, the plan of care for 'Being safe and free from harm' was well written and stated: 'Please use phrases my (Family member) uses (as I understand them).' Two examples were then recorded around anxiety.

We 'pathway tracked' the care of one person who required support with a particular personal care need, which increased their anxiety. However, staff at the home had not received any training in relation to this specific area of need and had not sought advice from relevant health care professionals. The plan of care identified the assessed need, but did not provide staff with clear guidance around the proper management of this or the wearing of Personal Protective Equipment whilst carrying out the procedure. A risk assessment gave staff some basic instructions, but these were insufficient, as they lacked clarity and guidance about how to maintain good care practices, in order to prevent infection. Records showed health care professionals had been involved in supporting this individual two months after admission to the home. They instructed staff how to keep the area clean and informed them this procedure should be carried out twice a

day, in order to promote good infection control practices and to keep the area free from sores and excoriation. This procedure had evidently not been carried out since admission to the home seven weeks previously. This did not promote good infection control practices.

There was a letter on the care file of one person from a medical professional, which stated, 'Significant vascular disease. Mild cognitive impairment.' A risk assessment indicated the person had short term memory loss and had been seen in the memory clinic. This assessment stated that intervention around memory loss was listed in the support plan and that any advice from health professionals was to be followed and written into the care plan. Twelve members of staff had signed to show they had read the risk assessment, but none had identified there was no support plan in place around the individual's mental health needs. Therefore, this did not promote person centred care.

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.

This resulted in a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

The manager of the home told us that staff had been enrolled to complete an end of life care training programme. This would help the staff team to understand the compassion needed towards people and their families during the final days of life. 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 techniques. People who lived at Melrose had relatively low level needs and therefore information was accessible. One person whose first language was not English communicated through a relative, who visited daily.

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. However, this did not provide people with contact details of the relevant external organisations, such as the local authority. A robust system had not been introduced for recording the receipt of complaints, as these were retained on individual care files, which made it difficult to implement a clear auditing system. It is recommended that the complaints procedure be updated with relevant information and a system be implemented to allow the provider to thoroughly assess and monitor any complaints received.

There was limited evidence of activities taking place on the day of our inspection. One person we spoke with said, "There's not much going on, but we watch TV and there is an odd sing-along." Another commented, "It would be nice to do something, rather than just sit here." 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 saw staff dancing with people in the lounge area at the end of our inspection. It was clear people were enjoying this activity with staff.

We overheard a member of staff ask one person, "When would you like your bath?" This person replied by saying, "Oh, I don't want one today." The member of staff responded, "Maybe tomorrow then, but if you change your mind just let me know." This demonstrated people were offered choices and were able to make their own decisions about the support they received.

Requires Improvement

Is the service well-led?

Our findings

One person we spoke with told us, "[Name of manager] is very good you know." Another commented, "The home is very comfortable. The staff are lovely and I feel very happy being here." A third said, "I wouldn't want to be anywhere else. I have a comfortable room and the food is marvellous."

The manager was on duty at the time of our inspection. She had been in post for a period of four months and was in the process of submitting an application to the Care Quality Commission to become the registered manager of Melrose Residential Home.

We received positive feedback from staff about the new manager and changes implemented since her appointment. A member of staff commented, "[Manager's name] is a brilliant manager. There has been a positive difference since she came. You can go to her with a problem and she sorts it out." Another told us, "The manager is wonderful; very supportive. She is open and honest and is making a difference."

The manager demonstrated a good knowledge and understanding of the improvements required, however a number of issues identified at the last inspection were still evident. The manager recognised areas still in need of improvement.

At the last inspection we found the provider had not ensured that effective systems had been established in order to assess and monitor the quality of service provided. At this inspection we assessed the systems for monitoring the quality of service provided. We found the quality monitoring, governance and oversight systems had improved since our last inspection, although further improvements were still needed.

We also found the provider's understanding of the regulations was poor. By way of example, we saw the last medication competency assessment for the senior care assistant who was administering medicines on the day of our inspection was conducted on 26 July 2017 and had been signed by the provider. This indicated that the provider had completed the competency assessment herself. However, there was no evidence available to show the provider had undertaken medication training, in order to demonstrate their competence to assess the management of medicines. We questioned this and were informed that the assessment had in fact been completed by a professional person from the local authority during a period of support for the home, and they had not signed it. The provider felt it required a signature from a senior person in the home and therefore signed it themselves. We were able to confirm the assessment had been completed correctly, but not signed at the time. However, this demonstrated the provider's lack of understanding.

The visions and values of the service had not been established at the time of our inspection. The manager told us the staff team were going to develop these in the near future. 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.' However, this was found to contain obsolete information, as it referred to the previous manager of the home and the

Commission for Social Care Inspection (CSCI), which was the previous organisation prior to the Care Quality Commission (CQC) being established in 2009. Therefore, this document had not been updated for nine years.

The Service Users' Guide also informed its readers that a wide range of activities were available at the home and that people could continue to enjoy their pursuits, hobbies and leisure interests whilst living at the home. However, this information was inaccurate and misleading as there was little evidence available to demonstrate activities were provided for those who lived at Melrose.

There were no audits in place in order to monitor the quality of care planning, the environment, nutrition, risk assessing, medications, fire safety, record keeping or recruitment.

We noted a large amount of confidential paperwork to be left on the office desk with the door open and the area vacant of staff members. This did not promote security of personal records, in accordance with data protection guidelines.

The policies and procedures of the home were due for reviewing and updating in August 2016. This had not been done and therefore information and guidance for staff was potentially out of date. The manager told us she planned to tailor these to the needs of Melrose and the people who lived there, as she found them to be very generic and lacked specific detail. This would help to ensure the staff team were provided with current legislation and up to date guidance.

Although some improvements had been made since our last inspection, we would expect the provider to have moved the service on further, so that systems and practices were implemented, which protected people from potential harm and provided them with a good standard of service.

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

Surveys had been completed by those who lived at the home and their relatives since our last inspection. These demonstrated good use of picture formats to represent people's views. This enabled everyone to experience the same opportunities, by enabling them to provide feedback about the service provided, which supported equality and human rights.

Records showed that regular residents', relatives' and team meetings were now being held. This enabled any relevant information to be disseminated and allowed interested parties to discuss any topics of interest, concerns identified or areas of good practice within an open forum. This encouraged a transparent and accountable culture within the home.

The manager told us that a representative of the provider visited the home three times a week to provide support in relation to maintenance and the premises. Records showed that the provider conducted regular unannounced visits to the home, which included speaking with people who lived at the home and in January she attended a senior care workers' meeting. Some care files we saw recorded involvement with community professionals, such as GPs, district nurses, chiropodists and mental health teams.

The manager confirmed the provider conducted her supervision sessions, which enabled her to discuss work performance and management skills, as well as additional training needs. However due to the lack of knowledge of the provider the manager has sought assistance for peer support from another home with the assistance of the local authority.

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.

The previous rating awarded by the Care Quality Commission was displayed within the home. One care worker we spoke with told us, "Things have changed for the better since the last inspection. It's loads better and there is loads more training. The new manager is nice. I could go to her and she would sort things out. I feel well supported."

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 The provider had not ensured that the planning of people's care was always person centred.

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 The provider had not ensure that a robust risk management framework had been adequately implemented and guidance from community health care professionals had been followed in day to day practice. The provider had not ensure sufficient infection control practices had been introduced in relation to the cleanliness of the catering facilities. The provider had not ensured accurate records, regular checks and appropriate action in relation to fire safety requirements and guidance.

The enforcement action we took:

Warning notice served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that sufficient improvements had been made to the governance and oversight systems, in order to effectively assess and monitor the quality of service provided.

The enforcement action we took:

Warning Notice served