Skitini Care Homes Limited

# Melody Lodge

## Inspection report

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## Ratings

| Overall rating for this service | Inadequate |
|---|---|

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

# Summary of findings

## Overall summary

About the service: Melody Lodge is a care home that provides accommodation with support for up to 11 people with a learning disability or autistic spectrum disorder. On the day of our visit there were seven people using the service.

The care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

People's experience of using this service: The culture of the service was poor. The registered manager and staff did not recognise or understand their practice placed restrictions on people.

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. Consent to care and treatment was not sought in line with the principles of The Mental Capacity Act 2005 (MCA).

Whistleblowing procedures were ineffective. Staff raised concerns with the registered manager and provider but did not escalate their concerns with other authorities when they failed to act.

Incidents of a safeguarding nature were not reported to CQC.

Timely action had not been taken to address concerns regarding the environment. This placed people at risk of avoidable harm.

Staff had not been recruited safely as all of the relevant checks had not been completed and there were not enough staff employed to meet people needs.

People were not always treated with dignity and respect. Staff did not follow best practice guidelines and positive behaviour support strategies were not used. Punitive practice was embedded within the culture of the home.

The service was not well led. People had experienced restrictions to their liberty because of poor practice and ineffective governance systems and processes.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Rating at the last inspection: The service was rated as good and the report was published in June 2016.

Follow up: Following the inspection we referred our concerns to the local authority responsible for

safeguarding. In addition, we requested an action plan from the provider, and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by the Care Quality Commission (CQC). The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe

Details are in our Safe findings below.

### Is the service effective?

**Requires Improvement**

The service was not always effective

Details are in our Effective findings below.

### Is the service caring?

**Inadequate**

The service was not caring.

Details are in our Caring findings below.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive

Details are in our Responsive findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led

Details are in our Well-Led findings below.

# Melody Lodge

**Detailed findings**

## Background to this inspection

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

Inspection team: The inspection team consisted of one adult social care inspector.

Service and service type: The service is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did: Prior to the inspection, we checked all the information we had received about the service. We assessed the information received in the Provider Information Return (PIR). This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

We contacted the local authority commissioning and safeguarding teams and the local Healthwatch. Healthwatch are a consumer champion in health and care. They ensure the voice of the consumer is heard by those who commission, deliver and regulate health and care services.

During the inspection we spoke with five people who used the service.

During the inspection we spent time in the communal areas of the home observing how staff interacted with people and supported them. The registered manager was not present during the site visit. On the first day of the inspection we spoke with two staff and two relatives. We made phone calls to the registered manger and

a further two staff. We concluded this inspection activity on 4 January 2019.

We reviewed a range of care records for six people. We looked at three staff personnel files, in addition to a range of records in relation to the safety and management of the service. After the inspection the registered manager sent us further information which we had requested.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse.
• People told us that they felt safe however, despite this feedback we found significant concerns about the safety of the home.
• Staff did not recognise and respond appropriately to abuse. We viewed care records and saw physical altercations between people living at the home had not been responded to appropriately. Incidents had not always been reported to the correct authorities.
• Staff did not understand whistle-blowing procedures. Staff told us they had raised concerns about the home to the registered manager and provider. However, when issues were not resolved they did not escalate these concerns to other authorities.

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

• The provider had not notified CQC of all safeguarding allegations. This meant that the CQC did not have oversight of all safeguarding allegations to make sure appropriate action had been taken.

This was a breach of regulation 18 of the Care Quality Commission Registration Regulations 2009. Notification of other incidents. This is being followed up and we will report on any action once it is complete.

Assessing risk, safety monitoring and management; Preventing and controlling infection.
• The heating and hot water systems were inadequate. On the day of the inspection the heating within the home was not working and the environment was cold. Staff told us they did not have access to alter the heating temperatures. Staff said, "Sometimes heating and maintenance are not good, there's a lack of heating and hot water. Water doesn't stay hot all day."
• People told us they had to wash in cold showers. One person told us, "It's been chilly, very chilly in here today. It's like that all the time because we have an old water tank. We have to have a shower in cold water and boil kettles to wash the dishes downstairs."
• Some risk assessments were not sufficiently clear to guide staff in the actions they should take in the event of an emergency. For example, a risk assessment for a person with epilepsy gave staff the choice of contacting 111 or 999 in the event of seizure activity.
• Risk assessments were not in place for restraint practices. The registered manager told us people were not restrained. However, we viewed documentation for one incident which described staff working in ways to control people's behaviour to prevent them from doing something. This placed people at risk of harm.
• Following the inspection visit we received feedback from the local authority. They told us during their monitoring visit there was a strong malodour within one bedroom. This was found to be due to a soiled

mattress. No waterproof cover had been used to protect the mattress and the bed re-made with clean bedding without replacing the contaminated mattress.

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

Staffing levels and recruitment.
• Safe recruitment practices had not been followed. We reviewed records for three staff and found shortfalls with all recruitment checks.
• Gaps in the employment history for potential employees had not been considered in the recruitment process; appropriate pre- employment checks had not always been completed for example, checking references.

Failure to carry out relevant and robust recruitment checks for staff is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There were not always enough staff on duty to meet people's needs. On the day of the inspection one member of staff had been delayed in arriving at the home. As cover could not be arranged this resulted in a planned activity being cancelled. The person impacted by this change was reassured by staff their activity would take place at a later date.
• Agency staff were used to support the home. However, we were told that it was not always possible to cover some shifts.
• We received mixed feedback regarding staffing levels. We were told that there were little opportunities for people to go out at weekends. Comments included, "It's usually more difficult to get people out at weekends but through the week it isn't a problem."
• The provider used closed-circuit television (CCTV) to monitor people's behaviour. Staff told us, "It's used to determine what has happened if someone reports an incident, we can then check video footage to clarify what has happened."

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

Learning lessons when things go wrong.
• Accident and incident were not always recorded or responded to appropriately. Staff told us information was shared at handover meetings but sometimes records were archived too quickly so they did not get the opportunity to view them.
• Staff did not reflect on their practice to consider better ways of working.

Using medicines safely.
• Medicines were managed safely. Medicines records were completed and showed people had received their medicines as prescribed.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance.
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The registered manager had not always followed the principles and guidance related to MCA and Deprivation of Liberty Safeguards (DoLS) authorisations.
• Staffed supported people in ways which restricted them. However, staff did not understand their practice was restrictive. We observed one person ask staff for some chocolate, they were told, "They've been put away at the minute because of your behaviour the other day. You have to learn don't you."
• One staff member confirmed they thought the practice at the home could sometimes be restrictive and that people did not always have choice.
• Capacity assessments had not been completed for decisions made on behalf of people. For example, the use of CCTV to observe people's behaviour.

The principles of the MCA had not always been followed, therefore this is a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• An assessment of people's needs had been completed. They did not demonstrate that people were involved in the planning of their care.
• Support plans contained some person-centred information but varied in the amount of detail they contained.
• Records were reviewed and updated when a change in need was identified for the person.

Staff support: induction, training, skills and experience.

• Staff, including the registered manager were not supporting people in a person-centred and did not understand positive behaviour support principles.
• Staff told us they received in-house training provided by the registered manager. We judged this was not sufficient due to the registered managers lack of knowledge in certain areas.

Supporting people to eat and drink enough to maintain a balanced diet.
• Staff were knowledgeable about people's dietary needs and preferences and people told us they liked the food. However, we received mixed feedback from staff regarding the food choices available. Comments included, "I wouldn't be happy for one of my relatives to live here [Melody Lodge] because of things like fresh fruit and veg not being available for days."
• Drinks were available to people for them to remain hydrated. Staff told us a water cooler in the home had been removed and a filter applied for tap water. They said, "The water is cloudy, I won't drink it because of how it looks and neither will [name of provider]. To have something nice and then have it taken away from you is not good. I just think if [name of provider] won't drink it why do they expect other people to?"

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
• People were supported to have access to a range of healthcare professionals to ensure they remained healthy. People received a learning disability annual health check with their local GP surgery and had 'my profile passports'. The information recorded in the passport helps staff in hospitals and GP surgeries to make reasonable adjustments to support safe and effective care for people with learning disabilities when attending health appointments.

Adapting service, design, decoration to meet people's needs.
• The home needed refurbishment in many areas. We saw wallpaper falling off, paint chips in many areas and a hole in a wall next to pipework.
• The home and garden were undergoing substantial building work. We were told this had been on-going for a number of years.
• People told us they were involved in decisions about the decoration of their bedrooms and could personalise them with furniture and belongings of their choosing.

Inadequate

# Is the service caring?

## Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect.

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported; equality and diversity; Respecting and promoting people's privacy, dignity and independence.
• Inclusion, equality and diversity were not promoted for people. Support was not always provided in a person-centred way and people's rights were not promoted.
• People were not always treated with dignity and respect. Staff told us they sometimes had to improvise by boiling kettles to provide hot water for people to wash. This was due to there not always being a supply of hot water available.
• Staff did not recognise they worked in ways which did not promote people's dignity. We saw of collage of mugshot photographs had been created depicting people as prison convicts. In the mugshots people were holding a board which documented their conviction. Staff had recorded convictions that were associated with the person's disability.
• Punitive practices were used by staff. For example, we viewed records which described punishments for people if they had behaved in ways which challenged staff. This included people being denied an outing or activity and being sent to their room.
• The use of positive behaviour support was not understood by staff. Positive behaviour support is a behaviour management system used to understand distressed behaviour and guide staff on the actions to take to help reduce anxiety and distress. One staff said, "I would liken it [people's behaviour] to toddlers having an incident."
• Staff described ways in which they worked to maintain the privacy of the people they supported. However, due to the use of CCTV in communal areas this was not always possible. One staff told us, "One person will sometimes come out of their bedroom [after bathing] and I try to protect their privacy because of the CCTV cameras."

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

• People's confidential information was stored securely and could be located when required. This meant that people's confidentiality was maintained as only people authorised to look at records could view them. Staff told us they cared about the people they supported. We did observe some positive interactions with people during the inspection.

Supporting people to express their views and be involved in making decisions about their care.
• Information was available for people in accessible formats. For example, easy read documents had been produced for people who could not understand written words.

• People's communication needs were recorded in care plans.
• Advocacy services had been used to support people. An advocate helps people to access information and to be involved in decisions about their lives.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means that the service met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns.
• People and staff told us they had raised concerns with the registered manager and provider regarding the heating and hot water system. One person said, "I tell [name of provider] and [name of registered manager] and the staff [about the heating and hot water] they just say they [engineers] are coming out in a minute. I say the water is freezing cold, can you do something about it. They say they'll get them [engineers] out to fix it but they've gone off on holiday and left it broken."
• There was no evidence these complaints had been recorded, investigated or responded to.

This was a breach of breach of Regulation 16 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

End of life care and support.
• End of life care plans were not in place. Staff had spoken with some people regarding their wishes for their end of life care. These conversations had not been formally recorded in care plans. The registered manager told us they had contacted social care professionals to request their involvement to develop care plans with people.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• People did not receive personalised care and support specific to their needs and preferences. Staff did not understand the principles of positive behaviour support and did not follow best practice guidelines.
• People were not encouraged or empowered to make choices about their support and independence was not promoted.
• Staff worked in ways which restricted people from making their own choices. Comments from staff included, "I think sometimes people's choices could be considered more."
• Activities were available to people within the home. However, staff told us there were limited opportunities for people to access their local community during weekends. Choices of activities were offered to people within the home when there were no opportunities to go out.
• Care plans reflected involvement with other health and social care professionals.
• Visitors were welcomed into the home. Staff supported people to maintain relationships with their family.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
• The leadership of the service were ineffective. This led to unsafe practice for example, the provider and registered manager were not aware of the concerns we raised during our inspection.
• An effective system was not in place to ensure notifications were submitted to CQC; the registered manager did not understand their legal responsibilities in what they had to notify to CQC.
• Timely action had not been taken to address the concerns regarding the environment which placed people at risk.
• A culture of high quality, person-centred care which valued and respected people's rights was not promoted.
• Systems for staff to summon assistance out of hours had failed. One staff told us, "I once activated the on-call but couldn't get through to anyone. [Name of registered manager] told me they didn't answer their phone as the call was from an unknown number."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others.
• There was a lack of evidence to demonstrate what action had been taken in response to concerns raised by people and staff.
• Staff told us they did not feel supported by the provider when raising concerns regarding the lack of hot water and heating.
• Nine breaches of regulations were identified during the inspection.
• The systems in place to monitor the quality of the service were ineffective. The registered manager did not understand current best practice guidelines therefore, had not recognised the negative culture, restrictive and punitive practices used by staff.

These issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider used surveys to obtain the views of relatives.
• Staff told us they felt supported by the registered manager; staff received supervision and appraisals in line with the providers policy. Comments included, "You can go and sit and talk to [name of registered manager]. They are approachable, you don't have to wait for a supervision."
• We received positive feedback from relatives regarding the approachability of the registered manager.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Effective systems were not fully in place to protect people from the risk of abuse. Regulation 13 (1)(2)(3)(6)(b)(c)(d). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>An effective system was not fully in place for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (1)(2). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service nor to monitor and mitigate the risks to the health, safety and welfare of people who used the service. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment procedures were not operated effectively to ensure only suitable staff were employed who had the necessary competence, skills and experience. Regulation 19 |

(1)(a)(b)(2)(a)(3)(a).

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always treated with dignity and respect. Regulation 10 (1). |

**The enforcement action we took:**

We imposed conditions upon the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005. Regulation 11 (1)(2)(3). |

**The enforcement action we took:**

We imposed conditions upon the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Not all risks had been assessed or action taken to reduce the risk of harm. Action to ensure the premises were safe was not taken in a timely manner. There were shortfalls with the plumbing and heating systems. Regulation 12 (1)(2)(a)(b)(d). |

**The enforcement action we took:**

We imposed conditions upon the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>An effective system was not fully in place to ensure there were sufficient staff to meet people's needs and on-call systems had failed. Staff did not receive appropriate training and support to enable them to carry out their duties they were employed to perform. Regulation 18 (1)(a). |

**The enforcement action we took:**

We imposed conditions upon the providers registration.