Melrose Care Limited

Melrose Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 14, 18 and 19 April 2016.

Melrose Care Home is a 26 bedded nursing home that provides nursing care and support to older people. At the time of inspection there were 22 people living at the home. It is also registered to provide personal care to older people in their own homes. This regulated activity is included in the registration of the care home and operates from the same location. At the time of our inspection Melrose Care Home was providing a personal care service to five people.

The service has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with told us they felt safe. They knew what to do if they felt they had been badly treated or if they wished to complain. Staff confirmed they had been trained in how to identify and report any incidents of abuse they may witness.

Any potential risks to individual people had been identified and appropriately managed. For example, people at risk of pressure wounds had received appropriate nursing care to reduce the risk of their occurrence or recurrence.

People's medicines had been administered and managed safely.

There were sufficient numbers of staff on duty with the necessary skills and experience to meet people's needs. Where people received personal care at home, the service had systems in place to allocate calls and to ensure consistency of staffing so that the staff visiting people understood their needs and knew how they liked to be supported.

Staff supported people to prepare meals and to eat and drink if required. They ensured people at risk of malnutrition received adequate nutrition and hydration.

The registered manager and staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We were informed that, currently, two people lacked capacity to make decisions for themselves. Appropriate steps had been taken to ensure decisions made on their behalf were in their best interests. No one required a DoLS to be put in place to protect their rights.

People were provided with support to access health care services in order to meet their needs.

Positive, caring relationships had been developed with staff to ensure people received the support they needed. They were encouraged to express their views and to be actively involved in making decisions about the support they received to maintain the lifestyle they have chosen.

Melrose Care Home had achieved a nationally recognised accreditation in end of life care through the Gold Standards Framework and has also been awarding the GSF Beacon Status in 2012 and 2015 which recognised their sustained good practice in this area of care. In 2015 they achieved the GSF Care Home of the Year award which was given in recognition of their commitment to providing high quality of end of life care.

The culture of the service was open, transparent and supportive. People and their relatives were encouraged to express their views and make suggestions so they may be used by the provider to make improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people had been managed safely. Records demonstrated, where risks had been identified, action had been taken to reduce them where possible.

People's safety had been promoted because staff understood how to identify and report abuse.

Sufficient numbers of suitable staff had been provided to keep people safe and to meet their needs.

Is the service effective?

Good

The service was effective.

People's care needs were managed effectively. Care records included sufficient detail to ensure people's needs had been met.

People were supported to have sufficient to eat and drink.

The majority of people accommodated had capacity to consent to their care. The registered manager demonstrated they understood the principles of the Mental Capacity Act 2005 (MCA) and how they should be used to protect people's human rights.

Is the service caring?

Good

The service was caring.

People were supported by kind and friendly staff who responded to their needs.

People's privacy and dignity had been promoted and respected.

The provider had achieved accreditation and commendations from the Gold Standards Framework in relation to their end of life care training and care provision.

Is the service responsive?

Good

The service was responsive.

People received care and support that was personalised and responsive to their individual needs.

They felt able to raise suggestions or concerns and the registered manager responded to any issues people raised.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a positive culture which was open and inclusive.

Staff were well supported and were clear about their roles and responsibilities.

Quality monitoring systems were in place to ensure in the quality of the service provided to people.

Melrose Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14, 18 and 19 April 2016 and was unannounced. The inspection team was made up of an inspector and a specialist advisor.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We examined this and other information we had about this service. This included previous inspection reports and statutory notifications the registered person had sent us. A notification is information about important events which the provider is required to tell us about by law. We used all of this information to help us decide which areas to focus on during the inspection.

We spoke with six people who lived at the service, two relatives who were visiting Melrose Care Home and one relative by telephone. We also spoke with two people who used the domiciliary care service by telephone We spoke with the provider, the registered manager, the deputy manager who was responsible for co-ordinating the domiciliary care service, two registered nurses, the chef, two care assistants and two housekeeping staff who were on duty. We also spoke with an external assessor, who was visiting staff who were undertaking the National Vocational Qualification (NVQ) in Health and Social Care, which is a nationally recognised training award.

We observed care and support being delivered in the lounge and dining areas. We also spent time during the afternoon observing the activities provided. We also observed medicines being administered at lunchtime.

We reviewed a range of records relating to the management of the home and the delivery of care. They included care records for two people who lived at Melrose Care Home and two people who received a domiciliary care service. Management records included the provider's quality assurance records, staff rotas for a period of four weeks, minutes of recent staff meetings and the training records of all the staff employed

at Melrose Care Home.

Good

Is the service safe?

Our findings

People told us they felt safe and free from harm. When we asked what it was like to live at Melrose Care Home one person said, "I am safe and comfortable." Another person said, "I like it here! The staff are marvellous and very kind." A relative of a person who received a service in their own home, confirmed their family member was safe. They told us, "My mother has been receiving domiciliary care from the provider for the past two years. There have been no incidents of concern."

People's safety had been promoted because staff understood how to identify and report abuse. Staff were aware of their responsibilities in relation to keeping people safe. They were able to tell us the different types of abuse that people might be at risk of and the signs that might indicate potential abuse. Staff also explained how they were expected to report any concerns to the manager or a senior member of staff. This was in line with local safeguarding procedures. Records showed that staff had received training to ensure they understood what was expected of them.

The registered manager informed us how they ensured people were not subject to bullying or abuse. "This is by providing indication training and regular training to staff, which includes how to identify and report allegations of abuse. Staff are also provided with regular supervision sessions and regular staff meetings where they can discuss any concerns."

There was a system in place to identify risks and protect people from harm. Risk assessments identified where people required help. For example, they identified people who were at risk of pressure sores, falling and malnourishment. Care records provided guidance for staff to follow to ensure identified risks had been reduced. Records we looked at also confirmed the action taken to reduce the risks identified. For example, we saw a repositioning chart, a record of food eaten and of fluids taken for someone was being nursed in bed. This demonstrated the care provided to ensure this person did not have pressure sores or was at risk of malnutrition or dehydration. Staff were knowledgeable about the needs of people and knew the level of care each person required to reduce identified risks. Where people received personal care at home risk assessments had also been carried out with regard to the person's home. They identified any possible risks to people and staff, together with guidance to reduce them, when staff visited to provide personal care. This included identifying a safe means of entry, how many staff were required to deliver care and the equipment that should be used.

In the entrance hall to Melrose Care Home floor plans of the premises were prominently displayed. Alongside the floor plans, the home's evacuation policy was also on display which provided guidance for staff to follow. The same floor plans and procedures were displayed at certain points throughout the home. This meant they were readily available to staff and emergency services in the event of emergency evacuation. We were also provided with documentary evidence that the fire alarms and fire doors have been tested weekly and that the alarms have been sounded at other unannounced times. Training records indicated staff have received fire evacuation training at regular intervals as required. The last fire safety audit of the premises under the Fire Safety Reform (Safety) Order 2005 took place on 19 October 2015. The report

indicated that the premises were broadly compliant with the order. Two items were identified which required attention. The registered manager has advised us they have been addressed. The PIR advised, 'All staff have regular fire training. The deputy manager takes the lead for fire prevention audits and the management team are trained in fire prevention.'

People confirmed there were enough staff on duty, however some people commented that sometimes they had to wait before their needs had been met. One person explained, "It can sometimes be a long wait, which is particularly awkward and uncomfortable when I am on the commode. Generally speaking they (the staff) come quickly. I don't complain because we all want the same thing at the same time. They come as soon as possible." Another person told us," It is very caring here. You get everything you want. But, sometimes the never seem to come quick enough." When we asked about this further, the person demonstrated by pushing the call bell which was located around her neck. Within seconds the call bell was answered by two members of staff. They knocked before answering and asked for permission to come to reset the call bell. A third person said, "They come as soon as they can. I've never waited longer than a few minutes." We discussed staffing levels with the registered manager and the provider. We were advised that some people had raised the subject of waiting for staff to arrive had been discussed at a recent resident meeting. In response, the provider had appointed additional staff to work in the mornings whose sole responsibility was to make beds and tidy people's rooms. The purpose of this was to ensure care assistants were available to answer call bells.

We were informed that between 8am and 8pm each day, there was a registered nurse on duty supported by a team of between five and six care assistants. Each night a registered nurse supported by a team of two care assistants were awake and on duty. In addition, housekeeping and catering staff, who were responsible for cleaning and tidying the premises, making beds, laundry work, and providing meals were on duty each day. We were provided with copies of staff rotas covering the period between 28 March 2016 and 24 April 2016. They confirmed these staffing levels had been maintained throughout these periods. We observed that, on the day we visited, the staffing levels described were sufficient to respond to and meet people's needs. The staff on duty also confirmed that staffing levels were sufficient to ensure people's needs had been met safely.

People using the domiciliary care service confirmed that there were enough staff to provide for their needs. One person explained. "The staff have never missed my scheduled visits. Generally they are never late. There is the odd occasion when the staff have been caught up in traffic but, if this happens, they will contact me to let me know." Another person said, "They (the staff) are very good people and are always punctual. They are highly knowledgeable about the care I need." We were shown copies of duty rotas for staff who provided domiciliary care which covered a period a period from 4 April 2016 to 1 May 2016. They identified which member of staff was allocated to visit which person. They demonstrated call times allocated to each member of staff were in line with those identified in care records. They also demonstrated that the same staff members had been allocated to the same person to ensure consistency.

There were effective staff recruitment and selection processes in place. We were informed that applicants were expected to complete and return an application form and to attend an interview. In addition, appropriate checks and references were sought to ensure any potential candidate was fit to work with people at risk. We looked at the recruitment records of two staff. They showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. The provider informed us via the PIR, 'People are protected from discrimination through careful recruitment practices.'

Storage arrangements for medicines were secure and were in accordance with appropriate guidelines. Medicine records were up to date, with no gaps or errors, which documented that people received their medicines as prescribed. Where people were prescribed when required (PRN) medicines there were clear protocols for their use. The nurse on duty had recorded the name of the medicine, the dosage date, time it was administered, the reason why it was administered together with the outcome. We spoke with one person who required pain relief from time to time. We asked what would happen if they should experience pain. They told us, "I am able to ask the staff for something when it gets painful." Records we looked at indicated only the nurse on duty administered medicines and all staff we spoke with confirmed this. The provider advised that 'Medication training and audits are a high priority.' We also saw that records of medicines received and disposed of had been appropriately maintained. At the time of this inspection, people who received the domiciliary care service did not require assistance with medicines from staff. This was either managed by the person or by their family members.

Good

Is the service effective?

Our findings

People and their relatives told us they found the staff to be competent and well trained. A relative told us, "I think the staff have been well trained. I often go in to the home and see they have a training session planned." One person who received a service from the domiciliary care team confirmed that staff who visited were competent. They told us, "One of the staff providing my care was, originally, a trained nurse whilst the other is an experienced carer who is studying for a nursing degree."

Staff we spoke with informed us of the training they had received to provide good quality care. This included first aid, fire safety, food hygiene, health and safety procedures, infection control, and manual handling. Training records we looked at confirmed that all staff, including those providing personal care in people's own homes, had received the mandatory training identified. In addition, records indicated training specific to the needs of individuals had been provided including, caring for people living with behaviours which challenged, dementia awareness, diabetes awareness, providing care to people who have swallowing difficulties, and understanding death and bereavement. Several staff had also achieved nationally recognised training in providing care. They included the Diploma in Health and Social Care and the Care Certificate. Where staff provided person care from the domiciliary service they had also received additional training in lone working and safe handling of medicines. They also demonstrated that the provider had a system for identifying when individual staff needed to receive refresher training or further updates to their training to ensure this remained updated.

Staff also confirmed they were well supported by the registered manager and more senior staff via effective induction and regular training opportunities, routine supervisions and staff meetings. Records we looked at confirmed the registered manager had held meetings with staff at least monthly. Meetings had been used by the management to communicate day to day issues related to the running of the service and provided staff with an opportunity to raise items and suggestions they had to improve the service provided. Meetings and supervision sessions had also been used to enable staff to discuss their role, what was expected of them and if they required further training or support.

Staff on duty demonstrated they understood their responsibilities under the Mental Capacity Act 2005 (MCA). They confirmed they understood the basic principles they were expected to put into practice. They also knew that, if a person lacked capacity, decisions would need to be made in the person's best interest. Training records indicated that the registered manager, all of the nurses and all care assistants, including those who provided care to people in their own homes, had received up to date training in this area.

The 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We were informed that, at the time of our visit, due to dementia two people had been assessed as lacking capacity to make decisions for themselves. The registered manager informed us applications for Deprivation of Liberty Safeguards (DoLS) had been made to the local authority on their behalf. DoLS protect the rights of

people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager also advised us that DoLS had not been authorised for these individuals because each person had been well represented by their family when decisions had to be taken to ensure care and treatment provided continued to be in their best interests. Records we looked at demonstrated that, following discussions with family members, best interest decisions had been made on their behalf. For example, following such a discussion, it had been agreed that bed rails should be provided for one person to reduce the risk of them falling out of bed. Records also demonstrated this practice had been reviewed twice in the last nine months to confirm it continued to be in their best interests. Discussions with people and their relatives with regard to advance care planning have also been documented to ensure people's wishes regarding end of life care will be followed.

The PIR confirmed, 'People are supported to make their own decisions and consent to treatment is sought whenever possible. Staff are trained and are aware of how to assess people using the MCA. DoLS applications have been made as necessary. People are supported in discussing advance care planning decision as soon as it is appropriate.'

We spoke with three people who were sitting in the dining room just before lunch was due to be served. Tables had been laid with linen table cloths, condiments and cold drinks. We noted one person was completing a menu form. They informed us that each day people were expected to complete this form to indicate their choice of meal for the following day. The form provided a choice for each of the three meals provided, that is breakfast, lunch and supper, and also a choice of the size of the meal required. One person told us, "The food is good here, even though we have different cooks. I have no complaints." We also spoke another person after lunch. They told us, "We have three chefs here and the menu changes regularly. There is a vegetarian choice and homemade soup every day." Another person sitting nearby confirmed this." We saw evidence that people had been routinely consulted about menus and choices during residents' meetings. People who were provided with personal care in their own homes informed us they catered for themselves. However, we were informed of instances, when someone was unwell, when visiting staff had ensured a hot meal was available for the person concerned.

People in the care home were observed enjoying their meal. There were sufficient numbers of staff available in the dining room to ensure everybody was served their meal whilst it was still hot. People who needed assistance were provided with sufficient time to enjoy their meal. Specialised equipment, such as non slip mats, adapted cutlery, beakers and straws were provided to enable people to be independent at mealtimes. When some staff went to serve meals to people in their rooms, one member of staff remained to assist people who needed this. When the member of staff spoke with a person, they knelt down so that they could listen to what was said and also to have eye contact with the person who was speaking. Where necessary, staff encouraged people to eat to ensure they had enough to eat and drink.

Care records included nutritional assessments and weight charts which identified if people were at risk of malnourishment. Where necessary, records provided staff with guidance to follow to ensure people at risk received adequate amounts of food and fluids. For example, one person required a pureed diet as they were at risk of choking. The registered manager confirmed that advice and guidance had been sought from dieticians and Speech and Language Therapists (SALT.) Staff were advised to ensure this person was sitting in an upright position whilst eating or drinking. They were also expected to ensure all food and fluids that the person had taken was recorded, and to make sure dietary supplements had been given as prescribed. Records we looked at were up to date and provided information about the amounts of food and fluids this person had taken each day.

People confirmed they had been well supported to maintain good health by having regular access to health care services. One person explained, "There are always fully trained staff on duty. I would tell the carer or head nurse if I was feeling unwell. If it was something that needed further investigation they would get on to the doctor for me, or I can always call a doctor at any time." Another person commented that they had recently spoken to the registered manager about seeing the dentist for a check-up. This person also advised us that, although they had not needed to see a doctor for some time, a chiropodist and a hairdresser came regularly to Melrose Care Home.

People who received personal care in their own homes confirmed they, or their relatives, were able to access health care services for themselves. However, we were informed visiting staff would suggest contacting their GP if the staff believed it would be beneficial to their health. Arrangements would also be made, where necessary, for a member of staff to accompany them to the surgery.

The registered manager confirmed that the nursing staff would phone the local surgery to arrange visits by the local GP. We were also advised that, when the GP visited them, people were able to see their GP in private. There were also occasions when it was possible to arrange for the person to go to the surgery for appointments such as hearing check-ups. Care records included information about GP visits and, where appropriate, details of treatment prescribed, which had been transferred into the person's care plan.

Good

Is the service caring?

Our findings

People gave us very positive feedback regarding the caring nature of the staff. One person told us, "I like it here. The staff are marvellous and very kind. Everybody, from nursing staff to care staff, understands what I need and I can't complement them highly enough." Another person told us, "It's very comfortable and there is a very homely atmosphere. I am very well looked after. The staff are happy to help at any time." A relative informed us, "It's so easy going and friendly. The staff are caring; they smile at us whilst they are working!" Another relative said, "The staff are very good, they are very caring. They are also very welcoming to the family when we visit."

People who received a service in their own homes also confirmed that the care provided was very good. One person explained, "They try to make me feel comfortable. I get the same staff so that they are consistent. It also means I do know who is coming and when." Another person told us, "I have no complaints. They treat me with respect and with dignity."

People, including those who received personal care at home, confirmed their privacy and dignity had been respected. Members of staff were able to explain what they were expected to do. This included shutting the bedroom or bathroom door when helping someone to undress. One member of staff, who worked in the care home, said, "I would use a towel to cover someone's top half when I am washing them. This means they are not completely uncovered. We are expected to hang a sign on someone's door when we are helping them. This says 'Care In Progress.'" We were also advised the purpose of this was to warn visitors to Melrose Care Home, or other members of staff, not to enter during this time. From our observations we found all staff were polite and respectful when speaking to people. They also knocked on people's doors and waited to be invited in. Doors were kept shut when personal care was being provided and signs were in use as described.

When asked how staff are expected to develop positive relationships with people the registered manager advised that prospective candidates were expected to complete a pre interview questionnaire, known as 'A Question of Care,' where they were asked questions about how personal care should be delivered. They also explained, "We use this to assess levels of compassion and aptitude of care when we are recruiting staff. During induction the issue of how quality care should be provided is also discussed, along with the culture of the home and who we are." In addition, we were informed that "Dignity" days were arranged by the provider to deliver specific training about how care should be delivered respectfully and to ensure staff maintained people's dignity. They had also been designed to reflect the values and culture of the service. Staff we spoke with confirmed the support and training they had received. One member of staff informed us, "When I meet a resident for the first time I will let them know who I am and I will have a chat with them so we can get to know each other. We need to be nice and caring towards residents. I think this reinforces a positive relationship with them."

We observed a number of interactions between staff and people throughout the day. All of these appeared to be warm and friendly with staff showing appropriate caring behaviour towards the residents. We also observed that attention had been paid to the appearance of people who required support with personal

care. People were smartly dressed, the ladies had their jewellery on, their hair was styled, nails polished and some had make up applied to their liking. We also saw that staff had made every effort to get to know people and to respect their choices. In one person's room we saw a large notice by the television to remind staff to, 'Please put Songs of Praise on for me on Sunday's BBC1'. We saw the same method used for another person who liked to watch 'Call the Midwife'. We were informed this person used to be a midwife and enjoyed reminiscing about their career.

We were advised of the Going the Extra Mile (GEM) award which was given to staff who demonstrated initiative and were prepared to do that bit extra in their work. The registered manager advised us, "This is a scheme where people, including people who received personal care in their own homes, or their relatives nominate staff for an award which demonstrates that they have demonstrated exceptional caring qualities." We spoke with one member of staff who had received this award. They told us they had received the award for being open and honest in advocating for an identified person's rights. This further empowered and recognised staff to demonstrate these values in their work consistently.

People we spoke with could not recall if they had been involved with creating their care plans. However, records we looked at demonstrated that people, or their relatives, had taken part in discussions about their needs on admission or when they began using the domiciliary care service. This information had been used to draw up care plans to ensure they reflected individual needs and wishes. The registered manager confirmed that people were supported to be involved in making decisions about the care they received. The registered manager, or her deputy, regularly spoke with people to determine if the care they received was appropriate to their needs and if any changes were required.

The registered manager advised us that, at the time of our inspection, one person was receiving end of life care. Care records we looked at included evidence of advanced decisions which had been made between the person, family members and the registered manager about the care and support they wanted during the last days of their life. This meant that the registered manager and staff were able to provide care and nursing care to the person in accordance with their wishes and preferences. Staff on duty were able to tell us what was expected on them during this period.
A visitor told us about the time their father was receiving palliative care at Melrose Care Home before he died four years ago. "My father loved it. The girls (the staff) were great. They were really upbeat, they were perfect at it. The nursing care was also provided very professionally. The family could come to see dad whenever we wanted. The registered manager and her staff were very, very supportive."
Melrose Care Home had achieved a nationally recognised accreditation in end of life care, known as the Gold Standards Framework, since 2009. The Gold Standards Framework is a comprehensive training programme in end of life care for staff working in health and social care settings. In 2012 and in 2015 they were awarded Beacon status, which is the highest award that can be achieved under GSF. To achieve this a home must demonstrate established good practice across at least 12 of the 20 standards. The provider's website stated that this award has meant that, '… the staff, led by the manager and her deputy, have undertaken and succeeded on a tough programme to improve the way we deal with end of life care. It's about enabling more to die with dignity, where they want, how they want and with whom they want.' We were advised that, as part of the service's end of life care practices, the registered manager carries out an 'after death analysis' which involves all of the staff employed and Melrose Care Home. The registered manager described this as, "…a reflective process for the continuous improvement of end of life care, as well as support for the staff involved."

The provider also advised us that they had been an active member of a steering group run by the local Clinical Commissioning Group (CCG) which has advised on practice with regard to end of life care provision in all care services across the county. Therefore they were involved in ensure best practice in end of life care

in their own service as well as in the wider health and social care community.
In additional to being awarded the Beacon Status from the Gold Standards Framework, Melrose Care had also been nominated for and won the GSF Care Home of the Year award in 2015. This is an annual award given by the Gold Standards Framework for their commitment to providing high quality end of life care.

Good

Is the service responsive?

Our findings

The provider's website described the service as, '…a second home and we strive to help residents build a life here they truly enjoy. We believe that age does not have to prevent learning and growth, with tailored programmes to each individuals needs we offer activities and classes that can challenge and also offer relaxation and comfort to our residents .' Our findings indicated that the provider had been successful in providing a homely environment where people enjoyed activities and lifestyles of their choosing.

People told us they were very satisfied with the levels of care provided. They had been consulted about their requirements and had given their consent. One person said, "I am looked after very well indeed. I am comfortable and the staff are very helpful." Another person said, "The staff are very caring. I'm fully satisfied." A relative explained, "I was involved in the early days when my mother was first admitted. I sat down with (registered manager) to discuss what she needed." A visiting professional told us, "Care practices I have observed in the care home are of a pretty high standard. Staff provide care in accordance with agreed ways of working in order to provide high quality care." One person who received personal care in their own home said, "I had a long session with (deputy manager) when we started. We went over everything I needed. From time to time (deputy manager) visits and takes this opportunity to update herself with what I need." Another person who received care in this way, told us, "We discussed my needs at the beginning and the times I wanted staff to call on me. They have come to see me a couple of times since then to see if anything needs to be changed."

The registered manager advised that, on admission, or before they commenced using the service, the needs of each person had been discussed with them, with the family and, if they had been admitted from hospital, with ward staff. We were informed that these discussions assisted the registered manager in formulating an assessment of the person's needs which in turn, was used to draw up a care plan. Care records we looked at, including those for people who received a domiciliary care service, confirmed this. The PIR confirmed, 'People have their needs assessed prior to admission and regularly thereafter. Adjustments are made in accordance with these, and their (people's) wishes.'

Staff we spoke with demonstrated they were knowledgeable about the individual needs and wishes of people. They were able to discuss in detail the needs of people and how they should be met. They advised us they were expected to refer to individual care plans to establish what was expected of them. They also informed us they attended hand over meetings at the beginning of their shift to learn about any changes to people's individual needs and wishes. We observed interactions between people and staff on duty. We observed staff seeking consent before undertaking any activities. They gave the person time to respond and make their choice before care was delivered.
One person told us, "The activities are quite good here, but other residents might prefer to sit and read the papers or just sit and be quiet in the Quiet Room." We were also informed that the range of activities provided included, arts and crafts, pottery, painting, card making, chair yoga and gardening activities.

We were informed that the staff had discovered that one person used to work as a librarian. With this in mind, the registered manager had asked them if she would like to take charge of the home's library. The

person had agreed to do so. We saw evidence that the books had been sorted and categorised and the person confirmed that they had done this with some assistance. We were also informed me that the person went to the local library every six weeks to select whatever genre, or specific books people had asked for, including 'Talking Books' for those who can't see .

A relative told us how staff have responded to their mother's particular needs. "When my mother arrived she had given up. In my experience, the level of care provided has turned my mother's whole outlook round. Now, she likes to get up early and to get dressed. This means she can be up and spend time reading and listening to the news. There is an activity programme, which my mother enjoys. They try to make sure there is something happening every day, 95% of which are usually outside entertainers."

During the afternoon we observed seven people participating in a regular communal gardening activity, provided by an external organisation. Representatives of the organisation informed us that they aimed to provide social and therapeutic horticulture activities in the local community. As it was a sunny day, the session was held outside in the garden. We observed the organisers taking the time to talk individually with people about the different types of plants and flowers, while also touching, smelling and talking about the different colours. People were clearly enjoying themselves and responded very positively to the session with much laughter and interaction between all participants.

The registered manager informed us how they ensured care had been personalised and responsive to people's needs. "We have asked people about their preferences, for example, if want a bath or a shower, how often they want this, what time they want to get up. We review this on a regular basis with the individual to make sure they still want this. We also ask each person to help us develop their life story or their personal history which is kept in their care record. We find that there also value in revisiting this information once someone has become settled with us. We often find that, at this point, they want to do more. The family will often tell us they want the person to do something, however we always leave the choice with the person." Care records we examined included this information and had been used to develop person centred care plans.

The provider has arranged meetings each month where people have been provided with an opportunity to voice their opinions of the service provided and offer suggestions with regard to how the service may be improved. The meeting has been chaired independently by a 'friend' of the care home and has taken place twice a year. We were shown the minutes of the last meeting, which took place on 22 January 2016. The items which were discussed included the activities programme, menus, complaints and compliments. There was also an item which had been raised by the management of the service where people were asked if the wished to be involved with interviewing prospective staff. In addition, there was an item where people could raise issues with the management. On this occasion people had raised concerns about a perceived shortage of staff. This was because people found they had to wait a long time for call bells to be answered. The registered manager showed us an action plan which had been drawn up in response to the issues discussed. A memo addressed to 'All residents at Melrose Care Home' had been drawn up which apologised to everyone for this and reassured people that actions had been taken with regard to the recruitment of new staff to reduce the likelihood of this occurring in the future. We were also advised that the registered manager had set up meetings with individuals who expressed a wish to discuss their feelings about this individually. We discussed how staffing numbers had been increased under the SAFE section. This identified how an additional member of staff had been delegated to make beds and to tidy rooms each day.

In addition, the provider sent out a satisfaction survey each year to seek feedback from people about their views of the service provided. We were shown a summary of the results from the last survey which had been shared with people. The majority of the comments received were very positive. They included, 'Mum is safe

and happy and well cared for, ' and 'Friendly and caring, where residents' needs are managed with dignity and respect at all times.' Some recommendations had also been made to improve the service. They included, 'Better communication with regard to review meetings,' and 'Some residents need staff to make time available just for a chat.' The summary included comments about the steps taken to action them. For example, 'We are trying to recruit some volunteers… Having more volunteers will also help residents who need more of a one to one chat now and then.'

The provider had visited people who received personal care in their own home in order obtain their views of the service provided. We were provided with a record of such visits which had taken place in December 2015. The comments made were very positive. For example one person had told the provider, 'Always pleased with everything. The staff are very willing and flexible.' One person had asked for their visit times to be changed. We were advised, when the provider spoke with the deputy manager they found this had already been done.

People, including those who received personal care in their own home, told us that they would know who to speak with if they had concerns or if they wished to make a complaint. They also confirmed they were confident that they would be listened to and their concerns taken seriously. The registered manager confirmed that a written complaint procedure was made available to people and their relatives. This was also on display in a communal area of Melrose Care Home. We were also advised that people or their families would be provided with opportunities to discuss any concerns they may have. We saw a record of complaints that had been kept, which indicated complaints received had been appropriately dealt with and to the satisfaction of the person who made the complaint.

Good

Is the service well-led?

Our findings

People knew the registered manager and the provider and spoke with warmth about them. One person told us, "I think they are ideal. I think it's an excellent place." A relative said, "The management understands how the care should be provided right down to the grass roots level. All of the staff are expected to be involved in providing care. There is a good level of team work."

People who used the domiciliary care service were also very complimentary about the registered manager and her deputy. One person said, "The management of the service is very good, because they are on the ball. They are watching things so they know what is going on. The service is also very reliable, it is not slap dash."

Throughout the inspection we observed many interactions between the provider and several people. It was clear they knew each person and addressed them in an appropriate manner. In turn, people greeted the provider very warmly and were clearly pleased to see her. During our conversations with people it was clear they were happy to approach either the provider or the registered manager if they wanted to raise any concerns or wished to make a complaint.

The provider's website included the following statement about the culture of the service. 'Our ethos is centred around individualism and dignity and we pride ourselves on our ability to cater to each resident's needs on this basis.' The registered manager advised us how this has been created. "Melrose Care Home is a place where we treat people with respect and dignity. We promote an open, honest, nurturing, and compassionate culture. We do this by getting to know the people to whom we provide a service and by developing a relationship with each person which is based on trust."

The provider demonstrated the openness and honesty of the culture by responding positively to the concerns expressed by people with regard to the length of time it took before call bells were answered. Please see the RESPONSIVE section for more details.

We spoke with a visiting health care professional who was responsible for the assessment of staff at Melrose Care Home who were currently receiving training which led to a nationally recognised qualification. Please see the EFFECTIVE section of this report for more details about training provided to staff. They informed us, "The atmosphere is really relaxed, calm and peaceful. It passes the 'Mum test.' This is a friendly well organised care home that actually cares for the residents. The management is always willing to accept feedback and will act upon it."

When we asked them about the culture of the service, a member of staff explained, "It is an open culture at Melrose Care Home. We can speak up and talk about what we need to at work. It feels comfortable to me, it feels homely. The support we get from the management is good. I always feel I can speak with them as they are always around. They make it quite clear what we are expected to do. This is covered in our induction training." Another member of staff said, "The residents are very much at the centre of things here. There is a nice friendly atmosphere. When we show people around they tell us they like the feel of the place. The managers have developed an ethos which is open, honest and very supportive. This means anyone can sit

with them to discuss any concerns they have."

Documentary evidence we looked at demonstrated how the service had been monitored. They included routine health and safety checks and maintenance of the environment, the management of medicines and infection control. There were also regular audits of complaints, accidents and incidents in order to determine if there were patterns or factors that could be learnt from. In addition care records and staff recruitment records had been routinely checked to ensure they had been kept accurately. Each audit included an action plan which identified when the work needed to be done by, and by whom to ensure compliance.