Axelbond Limited

Melrose Residential Home

Inspection report

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Leyland
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Melrose Residential Home is a residential care home which can support up to 26 people in one adapted building. On the first day of inspection support was being provided to 13 people aged 65 and over. Two new people had been admitted by the second day of inspection increasing support being provided to 15 people.

People's experience of using this service and what we found
There was not enough competent staff deployed effectively to meet people's needs and staff had not always been safely recruited. The home was not cleaned to a suitable standard to minimise the risk and spread of infection and staff were not routinely following safe practice guidelines to reduce this risk. This included poor use of personal protective equipment and ineffective monitoring and auditing of the environment. Where risk was identified, it was not managed in a timely or effective way, this included where people had an accident or required additional support to keep them safe. Medicines were not managed effectively. There was not the information needed to show when people may need particular medicines and records were not kept in line with best practice.
Guidance supplied to ensure people's human right to family life was protected, was not followed or implemented by the provider, despite clear prompts from the regulator of the requirement to provide better visiting arrangements for families and loved ones. Audits were not completed effectively to identify concerns and ensure people's needs were met. Whilst we saw some examples of involvement in how people received their care, recent feedback did not confirm this had continued during the pandemic. Previous enforcement action taken by the CQC to ensure action was taken to improve services had not been addressed and concerns continued to impact on the quality of care received by people living in the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was inadequate (published 06/05/2021). This focused inspection reviewed the key questions of safe and well led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has remained inadequate based on the findings of this inspection

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the deployment of staff and the management of risk, including infection control. A decision was made for us to inspect and examine those risks.
We inspected and found there was a concern with a lack of general improvement from the last inspection and ongoing breaches to the regulations were found in relation to risk management, staffing and person-centred care, including concerns about visiting restrictions. We widened the scope of the inspection to become a focused inspection which included the key questions of safe and well led. This inspection also followed up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well led section of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.
We have identified breaches in relation to the safe management of medicines, assessment and management of risk including, infection control, fire safety and people's welfare. We have also identified breaches in how staff are recruited and deployed to meet people's needs and concerns on how the service provided to people is monitored and overseen. We have issued a recommendation to ensure restrictive practice is assessed and implemented lawfully.

Due to concerns found at this inspection, we issued a Notice of Proposal to vary a condition to the providers registration to remove the location at Melrose residential care home, Leyland.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Melrose Residential Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
Melrose Residential Home 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, and both were looked at during this inspection.

The service did not have a manager registered with the CQC. This means the provider was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information we held about the service. The provider was not asked to complete a provider information return prior to the inspection. This is information we require providers to send us to give us key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

We sought feedback from the local safeguarding authority to help us plan the inspection effectively. We also reviewed information we held on the service, some of which was provided to us by members of the public. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service whilst on site and six relatives were contacted by our expert by experience via telephone. We also received feedback from five relatives following contact made by email. We spoke with seven members of staff, the interim manager and the deputy manager. During the inspection we reviewed incident and accident records, personal care records, personnel files and rotas and looked at the management information used to ascertain the quality of service provision. We also looked at the environment, including in people's bedrooms, communal areas and service areas including the laundry and kitchen.

After the inspection
We continued to communicate with the provider and management team following inspection. Further information was sent to us, but some information was not received despite numerous requests.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to provide a service which did not place people at risk of potential harm. This was because risks to people's health and safety were not being managed effectively. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- The provider did not have effective systems in place to ensure accidents and incidents were reviewed and learning from these was communicated to minimise the risk. This meant people were at risk of avoidable harm.
- Records showed a person was found at 6.40am in pain, the accident record reports they were not found until 8.10am and an ambulance was not called until 9am as it was a busy shift.
- Documents used to support people at increased risks were not completed correctly or fully, including records of food and fluid intake for those at risk of malnutrition and records for repositioning for those at risk of pressure sores.
- We reviewed the information used to ensure fire safety and protection procedures were in place and effective. We found the fire risk assessment did not address all areas of risk.

Systems to manage risk were not effective and this placed people at risk of avoidable harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to ensure staff had sufficient induction, training and supervision. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Concerns were also noted about the number of staff and their ability to meet people's needs in a timely way.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

- The provider had not ensured sufficient staff were deployed effectively. There was no dependency tool used to inform the provider how many staff were required to support people safely. Staff consistently told us

there were insufficient staff available to support people.
● We observed two people ask for support and there were no caring staff available to help them in the lounge area. The activities co-ordinator did not know the help people required. People had to wait until caring staff returned to the lounge, approximately 15 minutes later.
● Staff told us they had multiple roles. They explained this meant they undertook caring, cooking, laundry and light cleaning duties. Staff told us they did not always have time to complete all tasks. For example, we reviewed records for positional changes and saw these were not completed as required. We were not assured the positional changes had taken place and we received contradictory information from staff.
● Staff told us a lack of staff led to delays in support being provided. Two staff were needed to support people when using wheelchairs upstairs. Fire doors needed to be held open by one staff while another pushed the person in the wheelchair. Staff told us this meant the one remaining staff member would be responsible for supporting people elsewhere in the home. If two staff were required to support a person, they would need to wait.
● Staff told us they did not always have time to clean the kitchen as they prioritised people's needs first.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as insufficient staff were not always effectively deployed. This placed people at risk of avoidable harm.

At the last inspection we found recruitment practices did not complete robust checks to ensure potential employees were suitable for the role. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19

● We looked at the personnel records for four staff and found information was missing from their recruitment files. This left a risk of unsuitable staff being employed to support vulnerable people.
● Not all staff started their employment with an enhanced DBS check in place. We discussed this with the management at the home and advised them further checks were required. We were told these would be provided but these had not been received by time of writing this report.
● Staff did not have verified references from previous employment in social care and we found gaps in some employee's employment records, which had not been discussed at interview.
● We asked management to see their recruitment policy and were told one was not available.one was provided as part of the factual accuracy response.

The provider did not have robust recruitment procedures in place. The required checks were not always completed to ensure staff were suitable for the role. This is a continued a breach of regulation 19 (Fit and proper persons employed)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we found procedures for the safe management of medicines were not effective at ensuring medicines were administered safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The provider did not have effective oversight of medicines management and this left people at risk of receiving their medicines in a way other than how they were prescribed.
● One person had allergies recorded incorrectly on their medicine administration record, the record had not been checked by a second member of staff.
● Protocols and assessments for medicines to be taken as required, were not in place. There was no guidance around when the medicine should be administered, the impact it may have and how staff should monitor people after it had been administered.
● When we reviewed the rota we found both day and night shifts which did not have staff trained in medicines management. Day staff told us, there was no staff on duty through the night who could administer medicines and there was not an early morning medicines round. This meant medicines prescribed to be taken before food, or at rest were administered as people got up. We saw one occasion when a medicine to be given an hour before food was administered with the person's breakfast. Medicines were not always administered as prescribed.

The provider continued to lack effective procedures and practices for the safe administration of medicines. This is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure people were cared for in a clean and hygienic environment. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some toilet pedestals had dust, hair and urine stains on them. The walls in the kitchen were stained with grease and the oven was rusty and dirty. There was a build-up of dust, debris and some stale food under the catering units in the kitchen.
● Staff did not manage laundry practices safely. We observed clean washing hanging in a laundry next to bags of soiled clothing which were waiting to be washed. We also saw discarded solid laundry bags in the bin. We were told these had not dissolved properly in the machine, The bags are designed to dissolve at hot temperatures but this had not happened, this could increase the risk of cross contamination.
● We were not assured that the provider was managing and preventing infection outbreaks effectively. Some staff had artificial nails and were wearing rings with stones in them. This posed a risk of cross contamination and cross infection.
● We were not assured that the provider's infection prevention and control policy was up to date and that the named IPC leads had the required knowledge and skill in this area, to address the identified concerns.
● We were not assured that the provider was using PPE effectively and safely. We saw some staff not wearing masks and some masks being worn under the chin. Gloves and aprons used to support people with personal care were being removed in communal areas, rather than at the point of care delivery as required.
● We were not assured that the provider was meeting shielding and social distancing rules. The chairs in the lounge area were arranged tightly together. Each chair was used and occupied by a person during the inspection. Chairs were not cleaned in between use.
● We were not assured that the provider was admitting people safely to the service. Two new people had come to live in the home between the first and second day of inspection. There were no care plans and no

available information was gathered from their families around their vaccination status.

People were not protected from the risk and spread of infection, this evidence demonstrates that people, visitors and staff were placed at risk of avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was accessing testing for people using the service and staff.
● We discussed our findings with the management team and they assured us following the first day of inspection that they would deep clean areas of the home. On our second day of inspection we found this had not happened. We have signposted the provider to resources to develop their approach and have referred our findings to the local environmental health service and infection prevention and control team.

Visiting in care homes
During the inspection the provider had an outbreak and primarily health professionals were the only people able to visit the home for longer than 30 minutes. We discussed at length the requirements of the provider to ensure people's human rights were met and they were allowed access to family life by way of visitors. The management team told us they followed best practice and sought expert guidance from the local authority infection prevention and control team. We found this was not the case and encouraged the provider to revisit their visitor's guidance on at least three occasions. The provider assured us we would receive an updated version of the visitor guidance at the end of the inspection, but to date it has still not been received. During the inspection we received concerns from the public regarding visiting arrangements. We have signposted the provider to guidance to support their decision making and will follow this up outside of the inspection process.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and practices were in place to ensure people were protected from potential abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some action had been taken to meet this breach, but we had still had some concerns, for which we have issued a recommendation

● The last inspection identified concerns around the assessment of restrictive practice to ensure the least restrictive action was taken. This was still the case; we saw people had their legs elevated to reduce the risk of falls restricting their movement. When we looked at associated care plans and assessments there was not the required assessment or best interest decisions to support the action.

We recommend the provider reviews assessments for restrictive practice and ensures they are lawful.

● Systems had been developed for referring concerns in practice to the safeguarding authority,

We could not improve the rating for Safe from Inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to arrange suitable oversight of the service in order to assess, monitor and improve the quality, safety and welfare of service users, who were potentially at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● The provider had failed to arrange adequate oversight of the service. Audits we reviewed had not identified any of the concerns we identified on inspection.
● The provider had not achieved compliance with the regulations and there was no evidence of lessons learned and acted upon to drive improvement.
● Internal monitoring systems had not identified that accidents and incidents had not been investigated and lessons learned had not been shared.
● The provider did not have a registered manager and satisfactory steps have not been taken to recruit one within a reasonable timescale.
The provider had not taken steps to improve procedures at the home to ensure effective oversight was in place to keep people safe. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection we found the provider had not ensured guidance was consistently provided for staff about how people's needs were to be met in a person-centred way or how people were to be supported with the decision-making process. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of

regulation 9

● Systems in place to ensure care plans and risk assessments were an accurate reflection of a person's needs were not effective and records to support people with any additional support were ineffective
● Actions to be taken following accidents were not clearly recorded in care plans and risk assessments. One accident record stated two staff members were required to support a person following a fall. Their care plan stated, one to two people was required, dependent on the strength and experience of the staff member. This had not been reviewed and was ambiguous. Staff did not have clear guidance on how to safely support people. This placed people at risk of avoidable harm.
● We received mixed feedback from relatives regarding the service provided. Three relatives told us they felt their relative had deteriorated during the pandemic due to a lack of stimulation and visiting restrictions. Families had not been offered to be an essential care giver to support their loved one, in line with government guidance.
● There were two new people admitted to the home and contact had not been made with their families to identify their preferences, needs and choices. One family had a short visit and found their loved one without essential communication aids.
● One care plan we reviewed clearly identified a named individual played a key role in supporting the person with their good mental health, this person had been refused contact with the named individual due to visiting restrictions.

The provider had not ensured staff had accurate information to meet people's needs. The provider did not involve people or their representatives sufficiently in the developing and reviewing of their care plans ensuring their preferences, choices were identified and met. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others;
● The provider had not always acted on the duty of candour when something went wrong.
● Family members were not always notified when their relatives had been involved in accidents or incidents. This did not promote an open and honest culture.
● Staff members told us they often received mixed messages and when they offered solutions to issues, they were ignored.
● We requested information to assure us risks identified at this inspection were addressed, and action had been taken. Information was not received.
● The last inspection identified almost identical concerns to this inspection. Not sufficient action had been taken upon the information provided to identify breaches in regulation.
● We reviewed a warning notice for regulation 17 issued following the last inspection and none of the areas of concern had been rectified. We continued to have significant concerns around the providers ability to meet the requirements of their registration.

The provider did not act on relevant feedback about the quality of service provision. This put people at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not improve the rating for Well led from Inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider continued to not have robust recruitment procedures in place. The required checks were not always completed to ensure staff were suitable for the role. Regulation 19 (1) (a) (b) (2) (5)

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 9 HSCA RA Regulations 2014 Person-centred care People living in the home were not supported to meet their identified needs including access to visitors. Preferences and choices were not acquired and reviewed to ensure care was delivered how people wished.. Regulation 9 (1) (a) (b) (c) (2) (a) (b) (c) (d) (f) (g)

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from avoidable harm. The provider had not always done all that is reasonably practicable to mitigate risk, care and treatment was not always provided in a safe way and people were not protected from the risk and spread of infection. Medicines were not managed safely with not enough trained staff or available information to do so. 12 (1) (2) (b) (d) (g) (h)

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits and checks did not consistently identify shortfalls to drive improvement. The provider did not act on previous enforcement action and feedback provided by professionals

	17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not effectively deployed. 18 (1)

The enforcement action we took:

NOP to cancel registration