M Rashid

Melrose House

Inspection report

Melrose House
95 Alexandra Road
Southend On Sea
Essex
SS1 1HD

Tel: 01702340682
Website: www.melrosehouse.co.uk

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Melrose House provides accommodation, personal care and nursing care for up to 34 older people and older people living with dementia.

Following our inspection to the service in March 2016, an Urgent Notice of Decision was issued to the registered provider advising that no further admissions could be made to the service without the prior agreement of the Care Quality Commission (CQC). The overall rating for this provider was 'Inadequate'. This means that it was placed into 'Special measures' by CQC. In addition, the Care Quality Commission met with the registered provider on 11 April 2016 to discuss our on-going concerns. During the meeting the registered provider and registered manager gave an assurance that things would improve.

This inspection was completed on 1, 2 and 5 September 2016. There were 23 people living at the service when we inspected.

The overall rating for this provider is still 'Inadequate'. This means that the service remains in 'Special measures' by 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.

Because the service was in special measures already we inspected within the six months timeframe. Insufficient improvements had been made; we are now taking action in line with our enforcement procedures.

A registered manager was 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.

There was a lack of provider and managerial oversight of the service. Quality assurance checks and audits carried out by the registered manager were not robust, did not identify the issues we identified during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised. There was a reactive rather than proactive approach by the management team which meant that people did not receive a consistent safe and appropriate service. Lessons had not been learned and several areas of improvement had not been sustained in the longer term.

Staff were able to demonstrate an understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected, however the registered manager had failed to implement robust procedures and processes to make sure that people using the service were safeguarded and protected from abuse.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered. Risk assessments had not been developed for all areas of identified risk and had not always been completed to determine that these were suitable for the individual person so that any risks identified were balanced against the anticipated benefits. The management of medicines was not safe as people did not always receive their medicines as prescribed.

People did not think that there were sufficient numbers of staff available to meet their needs. Our observations showed that staffing levels and the deployment of staff were not always suitable. Staff did not always have time to spend with the people they supported to meet their needs and the majority of interactions by staff were routine and task orientated. People's comments about the care and support they received were variable. Whilst some staff's interactions with people were positive and staff had a good rapport with the people they supported, this was in contrast to other observations. These showed that some staffs practice required further improvement and development.

Suitable arrangements were not in place to ensure that the right staff were employed at the service. The implementation of staff training was not as effective as it should be so as to ensure that staff knew how to apply their training and provide safe and effective care to the people they supported. Robust systems were not in place for newly employed staff to receive a thorough induction. Although staff had received appropriate training relating to manual handling, staff did not recognise the importance of safe manual handling procedures in line with people's specific needs.

People's care and support needs had not always been identified and documented as required and reflected in their care plans. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Significant improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability. Assessments had been carried out where people living at the service were not able to make decisions for themselves, however the arrangements for the use of covert medication were poor and 'best interest' meetings to evidence decisions had not been considered.

The dining experience for people was positive and people had their nutrition and hydration needs met. People were supported to access appropriate services for their on-going healthcare needs. Where appropriate people were enabled and supported to be as independent as they wanted to be and people were treated with privacy, dignity and respect. People knew how to make or raise a concern or complaint.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Effective recruitment procedures were not in place to safeguard people using the service.

Suitable arrangements were not in place to ensure that there were sufficient numbers of staff available at all times and the deployment of staff was not always appropriate to support people safely.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

The management of medicines was not safe as people did not always receive them as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff felt unsupported by the management team and the provider's supervision arrangements were poor. Staff did not receive a robust induction and improvements were required to ensure that training provided was of a good quality and learning embedded into staffs practice.

Although assessments had been carried out where people living at the service were not able to make decisions for themselves, the arrangements for the use of covert medication were poor and 'best interest' meetings to evidence decisions had not been considered.

The dining experience for people was positive and people had their nutrition and hydration needs met.

People were supported to access appropriate services for their on-going healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although some people stated that staff treated them with care and kindness, care provided was often task focused and people said that staff did not sit and talk with them for any meaningful period of time. Staff communication with some people was poor. People did not always feel listened to or that their views were acted upon.

Where appropriate people were enabled and supported to be as independent as they wanted to be. People were treated with privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

People were not engaged in meaningful activities or supported to pursue pastimes that interested them.

Concerns and complaints were always taken seriously and responded to in good time.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight of the service as a whole. There was a reactive rather than proactive approach by the management team which meant that people did not receive a consistent safe and appropriate service.

The quality assurance system was not effective because it had not identified the areas of concern that we found and improvements previously made had not been sustained and used as a learning opportunity to improve care across the service.

Melrose House

Detailed findings

Background to this inspection

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

This inspection took place on 1, 2 and 5 September 2016 and was unannounced. The inspection team consisted of two inspectors on 1 and 2 September 2016 and one inspector on 5 September 2016. On 1 September 2016 the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and registered manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 17 people who used the service, eight members of care staff, three relatives, the provider, registered manager and the external consultant.

We reviewed six people's care plans and care records. We looked at the service's staff support records for 11 members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

At our last inspection on 29 and 31 March 2016 we found that suitable control measures were not in place to mitigate risks or potential risk of harm to people using the service. Sufficient numbers of staff were not available to meet people's needs and the deployment of staff was not appropriate with the majority of interactions being routine and task orientated. In addition, suitable arrangements were not in place to ensure that the right staff were employed at the service. We asked the provider to send us an action plan which outlined the actions they would take to make the necessary improvements. In response, the provider shared with us on 30 August 2016 their action plan detailing their progress to meet regulatory requirements. We found that the improvements they told us they would make had not been made and sustained to an appropriate standard.

At our last inspection in March 2016 it was unclear as to who was responsible for employing new staff at Melrose House. At this inspection the external consultant confirmed that they had been given this responsibility by the provider. We discussed this with the provider and registered manager and they confirmed this was accurate. The registered manager told us that primarily they were not involved with the overall process of selecting and appointing suitable applicants for the service and records available confirmed this. The provider told us that they left the decision of recruitment and selection to the external consultant and did not have any involvement. Although these arrangements were in place, we found that suitable measures were not in place to ensure that the right staff were employed at the service.

The provider's recruitment and selection procedures were not effective or robust to confirm that relevant checks had been undertaken when employing staff. For example, the application records for two members of staff showed that an application form had only been submitted after 11 and 15 days respectively following their interview with the provider's external consultant. Additionally, three members of staff were interviewed at the same time and in the same room. This showed that robust measures had not been undertaken to review information recorded within the candidates application form so as to enable the provider's representative to make an initial assessment as to the candidates relevant skills, education and experience for the role and; so as to narrow down whom to invite for interview and whether or not they were suitable.

We found that satisfactory evidence of conduct in eight staff members' personal files, in the form of references, had not been received prior to their employment at this service. A recent photograph was evident for one out of ten members of staff and not all proof of identification documents provided were decipherable. In addition we asked to see evidence of one profile for an agency member of staff utilised at the service within the last 10 days of the inspection. However, the external consultant and registered manager were unable to provide confirmation in writing from the external agency that all necessary employment checks had been carried out. No rationale could be provided for the lack of documentation.

Prior to the inspection concerns were expressed by an external source as to the provider's recruitment process. In particular this related to the provider's representative having employed a member of staff without receiving the result of the individual's DBS check and despite the fact that the member of staff had a

criminal history. Although a risk assessment had been completed in relation to their past criminal convictions, this was not robust and provided little evidence to show that further investigations prior to the member of staff being employed at the service had been undertaken. This showed that the provider had not operated a thorough and robust recruitment procedure in line with their own policy and procedure or with the Care Quality Commission's regulatory requirements. This meant that people could not be assured that their needs were met and protected by staff who were suitably qualified and had the skills and experience to perform their role.

This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff had received manual handling training since our last inspection in March 2016, on the second day of this inspection we saw moving and handling procedures for one person that were inappropriate and which placed them at significant risk of harm. The person was observed to be assisted to a standing position by two members of staff using an incorrect item of equipment [stand aid hoist] instead of a full hoist. The stand aid hoist is only suitable for people who are weight bearing or are able to support most of their own weight while standing. We discussed this with staff and they confirmed that the person was not able to weight bear or partially weight bear. This meant there was an increased risk of insufficient support for the person and increased their risk of falling. Staff were also seen to assist the person using a 'one size fits all' sling and not the correct one in relation to the person's size and build. The selection of the wrong sling can result in the person experiencing discomfort and increase the risk of them slipping through the sling. Neither member of staff could provide a rationale as to why the incorrect item of equipment was being used other than, "That's the way we have always done it." We checked the person's care plan and this reflected that a full hoist was required and that a medium sling should be used. We advised both members of staff and the registered manager of the above. When we returned to the service on 5 September 2016 staff were observed to use the correct hoist.

During the inspection it was brought to our attention by a relative that they were concerned about the condition of some of the service's equipment, namely wheelchairs used to transport people from one place to another. They told us when pointing to their relative sitting in a wheelchair, "Today's wheelchair is the best I've had, it's got everything intact. Normally there's no footrest, or even no brakes." We discussed this with staff and they told us, "Several of the wheelchairs had been put in the shed as they were not safe to use but over the last few months we have noticed most of them have come back into the home until you [CQC] said something yesterday. We knew the wheelchairs were not safe to use but what are we meant to do if we need to move the residents". On the first day of inspection, of nine wheelchairs checked we found that seven wheelchairs were not safe to use. Footplates did not always match or fit correctly, brakes were not always working and the hinges on one wheelchair were loose making it unsteady and able to move from side to side. This meant that the equipment in place was not 'fit for purpose' and placed people at potential risk of harm and injury. We discussed this with the registered manager and they told us that arrangements had been made for someone to visit later that evening to service and repair all of the wheelchairs. However, on the second day of inspection we found that although the service's maintenance person had checked the wheelchairs, the servicing and repairs made were inadequate and substandard. We intervened and requested that the registered manager contact a reputable contractor so they could service and repair all the wheelchairs in the service. This was to ensure they were in good working order and safe before they were used. An external contractor arrived on the second day of inspection and examined and repaired the wheelchairs where possible.

Two staff were observed on the first day of inspection to mobilise one person to the dining room using a wheelchair that was visibly too small for their size and build. We discussed this with staff and they confirmed

that the wheelchair belonged to another person living at the service and that they were aware that the wheelchair was too small for the person being transported. Although the registered manager and staff advised that consent had been sought from the person whose wheelchair it was to allow someone else to use it, consideration had not been given to assess the person so as to determine the type of mobility equipment most appropriate to meet their needs. The registered manager and staff were seemingly unaware that a 'one size fits all' course of action was unsuitable as it could place people at risk of discomfort. The external consultant and registered manager advised on the second day of inspection that four new wheelchairs had been ordered online. However, they confirmed that people had not been assessed prior to the order being placed as to their suitability.

There were 23 people living at the service, some people were living with dementia. We had identified several potential risks to their safety and wellbeing that had not been recognised or considered by the provider at the time of our inspection.

Not all windows on the first and second floors had effective restrictors in place to restrict the window from opening. Window restrictors were not in place for six bedroom windows and two windows on the second floor corridor. Although a barrier [metal bar] was in place across some of the windows, this was judged as unsuitable as people determined to exit the window could still do this without realising the risks and danger involved to their health and safety. We brought this to the provider and registered manager's attention. Following our inspection the provider wrote to us on 8 September 2016 and confirmed that all windows had been checked and fitted with a window restrictor.

Staff had not taken appropriate precautions to ensure that people living at the service were not able to gain access to substances hazardous to health, for example, keeping items locked in a cupboard when not in use. Two containers of bleach were located in a communal bathroom on the second floor. The bath had three commode pans and two buckets soaking in water that was diluted with bleach. This meant that procedures to safeguard people from substances hazardous to health had not been followed by staff and the above had placed people at potential risk of either mistaking the cleaning fluids suitable for drinking or act as an irritant to a person's skin. At the earliest opportunity we brought this to the registered manager's attention and immediate steps were taken by them to deploy a member of staff to make the environment safe.

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, this was inconsistently applied. Risks relating to other areas were not identified and suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service despite a 'Rag Rating' or 'traffic light' rating system as a visual cue of risk being in place. For example, one person was judged as being at risk of choking as they could eat very quickly at mealtimes. A risk assessment had not been considered to evidence suitable control measures put in place to mitigate the risk or potential risk of harm for the person using the service, for example, staff supporting the person at mealtimes so as to ensure that they ate slowly and chewed their food properly. At lunchtime the service user was observed eating their meal without staff support or assistance and little attention was paid by staff to monitor them so as to ensure their safety and wellbeing. The lack of monitoring showed that actions to mitigate any risks to the service user had not been addressed

Although people told us they received their medication as they should and at the times they needed them, the arrangements for the management of medicines were inconsistent and unsafe. We found that not all medicines were stored securely, for example, topical creams with active ingredients were found on top of two people's chest of drawers and the eye drops for one person no longer living at Melrose House were found in a room that people living at the service could easily access.

There were arrangements in place to record when medicines were received into the service and given to people. However, a member of staff told us that the Medication Administration Records [MAR] were inaccurate. On further discussion they confirmed that the registered manager had signed their own initials on the MAR form to indicate the date and quantity of medication received at the service and the member of staff's initials without them being actually present. This meant that the registered manager had adjusted the MAR form without the consent of the staff member.

We looked at the records for seven of the 23 people who used the service. In general these were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. However, the MAR form for one person showed that five of their morning medications on one day were not administered as the person was 'asleep'. This meant that the person had not received all of their prescribed medication in line with the prescriber's instructions. The MAR form for another person showed that they were prescribed Warfarin. The MAR form showed that they were prescribed Warfarin to reduce the risk of their blood from clotting. Whilst the person's blood test results issued by the anticoagulant clinic were readily available and recorded the specific Warfarin dose to be administered each day, the MAR form showed that entries had been recorded in advance for the period 1 September 2016 to 5 September 2016 inclusive. Additionally, the dose recorded for 5 September 2016 showed that the amount of Warfarin to be administered on this date was double the prescribed dose. This meant that there was a risk that the person could be given too much Warfarin and that their health and safety could be compromised.

Observation of the medication rounds showed this was completed with due regard to people's dignity. Records were available to show that staff who administered medication to people using the service had received appropriate training in 2015 and 2016. In addition to this staff had been assessed as to their continued competency to administer medication. However, one member of staff advised that although their competency assessment had been signed-off by the registered manager, not all elements of the competency assessment had been completed with them. We discussed this with the registered manager and they neither agreed nor denied what was told to us.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we were told that one person who used the service had recently disclosed to a member of day staff a safeguarding incident whilst being supported by a member of night staff. Although the member of staff alerted the registered manager and they in turn spoke with the person about the incident, no further action was taken. We discussed this with the registered manager and they confirmed that the latter was correct and no further action had been taken, for example, notifying the Local Authority Safeguarding team and the Commission as required. This meant that the provider and registered manager had failed to implement robust procedures and processes to make sure that people using the service were safeguarded and protected from abuse. They had also failed to follow their individual responsibility to identify and report potential abuse at the earliest opportunity.

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

People's comments about staffing levels were variable. Some people felt on occasions that there were insufficient staff available. One person told us, "Today the cleaner is caring because someone rang in sick, that means no cleaning and the laundry lady is in the kitchen cooking, so the laundry won't get done." Another person told us, "The staff are nice but they are not always around. Sometimes trying to get a member of staff's attention is very difficult. You hope someone is going to come into the lounge but they do

not always."

Six members of staff told us that staffing levels, as told to us by the registered manager, had not always been maintained. Staff told us that this impacted on the delivery of care to people using the service. Staff confirmed that they did not have time to sit and talk with people using the service and when short staffed people often had to wait for long periods of time for care and support to be provided, for example, assistance with some aspects of personal care. Staff also advised that when staffing levels were reduced, people residing on the ground floor and in communal lounge areas were often left without staff support for significant periods of time until personal care with others living at the service had been completed. Staff confirmed that they found these situations very demanding.

Care and support provided was routine and task orientated and this was evident from our observations. Our observations during the inspection showed that staff did not always have enough time to spend with the people they supported and the deployment of staff within the service placed people at risk of harm. For example, on the first day of inspection one person was sat in the smallest of the three communal lounge areas with no support for some considerable time. The person was observed to call out for staff and when we entered the communal lounge they looked very uncomfortable and were at risk of slipping from their chair. We brought this to a member of staff's attention and they assisted the person into a more comfortable position. On the second day of inspection this same communal lounge was left without staff support from 10.00 a.m. to 10.50 a.m. The same person on several occasions was observed to call out for staff but no one came to their assistance or enquired as to what they needed or how they were. Staff later told us that this person was on 15 minute observations as a result of being at risk of falls or at risk of slipping from their chair. Evidence of 15 minute observations were apparent for this person but not completed or maintained on the second day of inspection. This meant that the arrangements to mitigate risks for this person were not effective or safe.

Staff rosters for the period 25 July 2016 to 4 September 2016 inclusive showed that staffing levels as told to us by the registered manager were not always maintained and suggested that there were not always sufficient numbers of staff rostered to provide care and support to people using the service. The registered manager advised that this was often due to staff calling in sick at the last minute, staff not able to undertake their shift due to unforeseen circumstances and staff on annual leave. Additionally, we found that the staff rosters were not always accurate to reflect where changes had been made. Therefore it was not always possible to determine if staffing levels were appropriate or not, but taking into account the discrepancies in service's rotas, our observations, staff and people's voice; we judged the service to lack sufficient staff to effectively deploy resources across the site to support people and to meet their individual needs and preferences.

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

Steps had been taken by the provider since March 2016 to address the issues relating to the service's hot water temperatures. Appropriate temperatures were noted to discharge from wash hand basins in people's rooms, communal toilets and bathrooms.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 29 and 31 March 2016 we found that equipment within the kitchen and adjoining utility area were not properly maintained. Furthermore a hot water supply was not always readily available within people's bedrooms, the main kitchen or the adjoining utility area. Concerns were raised about the quality of the training provided for staff and training up-dates had not been provided so that staff had the right competencies and skills to carry out their role. An effective and robust induction system was not in place for newly appointed staff and staff did not feel supported by the registered manager or provider. Staff had not received regular supervision. We asked the provider to send us an action plan which outlined the actions they would take to make the necessary improvements. In response, the provider shared with us on 30 August 2016 their action plan detailing their progress to meet regulatory requirements. We found that not all of the improvements they told us they would make had been made and sustained to an appropriate standard.

Staff told us that they did not feel supported and valued by the registered manager or the provider. Significant improvements were needed to make sure that staff had a structured opportunity to discuss their practice and development and to ensure they continued to deliver care effectively for the people they supported.

Although staff had received one formal supervision since our last inspection in March 2016, information recorded was inadequate as it did not show that supervisory arrangements were robust or being monitored. For example, they did not provide in sufficient detail topics discussed, actions agreed or provide confirmation that actions highlighted during the supervision session had been reviewed and addressed. We discussed this with the registered manager and external consultant. The external consultant identified that a second document with more detail about the discussion held by the supervisor and supervisee should have been completed. The registered manager confirmed that the latter had not been completed; however three days after the inspection the registered manager provided additional supervision notes for 10 members of staff. Information recorded was still deemed to be ineffective and lacking as it did not provide in sufficient detail the topics discussed, actions agreed or provide confirmation that actions highlighted during the supervision session had been reviewed and dealt with. The registered manager confirmed that since the last inspection in March 2016 they had not received formal supervision from the provider despite the service being in 'Special Measures' and the service having an overall quality rating of 'Inadequate'.

The registered manager confirmed that all newly employed staff received a comprehensive induction. This related to both an 'in-house' orientation induction and completion of the Skills for Care 'Care Certificate' or an equivalent. The registered manager told us that in addition to the above staff were given the opportunity to 'shadow' and work alongside more experienced members of staff. The registered manager confirmed that this could be flexible according to a person's previous experience and level of competence. Although an 'in-house' orientation induction had been completed for each staff member employed since our last inspection in March 2016, the registered manager confirmed that no-one had completed the Skills for Care 'Care Certificate' or an equivalent. We discussed this with the registered manager however no rationale was provided as to why this had not been implemented and completed by staff employed. This was not in line

with the provider's induction policy and procedure. This meant that we could not be assured that staff had received a thorough induction that provided them with the skills and confidence to carry out their role and responsibilities effectively.

Not all staff were complimentary about the quality of the training provided. One member of staff told us that when they commenced employment at the service they received manual handling training from the external consultant. They stated that the training did not last long and did not include all appropriate manual handling equipment available in the service or provide an explanation as to what equipment should be used for specific people living at the service. They told us, "I am lucky I have worked in care before so I knew I needed to check people's care plans. This was not explained during the training. During the training there was a girl who had never worked in care before and as we walked out they asked me, 'what was that lady [external consultant] talking about'." Other staff members concluded that the training was satisfactory but only because they had got previous experience working in a care setting.

The registered manager provided us with a copy of the staff training matrix which they confirmed at the time of the inspection was up-to-date. However, following the inspection and on further review, we found that the information contained within the document was not accurate or up-to-date as one member of staff was no longer employed at the service and the registered manager was unable to clarify as to the name of one member of staff detailed on the training matrix. The training matrix showed that not all care staff had completed the provider's own recommended training. Following a verbal discussion with the registered manager on 14 September 2016, they confirmed that one member of staff who was employed on 16 August 2016 had only received training on 5 September 2016. One member of staff had raised with the registered manager in July 2016 during supervision that they were not confident to use the hoist despite having previously received manual handling training. However, there was no evidence to show that further training had been provided despite this disclosure.

This is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Although staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training, not all staff were able to demonstrate a basic understanding of MCA and DoLS and how these should be applied. Where people were deemed to have fluctuating capacity, an assessment had not always been completed to evidence how this affected them and the day-to-day decisions required to be made on their behalf by staff.

We found that the arrangements for the administration of covert medication for one person using the

service were not in accordance with the Mental Capacity Act (MCA) 2005. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink. Although there was evidence to show that the person's GP had agreed for all of their medications to be crushed, the registered manager had not instigated a 'best interest' meeting with all necessary parties involved. This is to agree a management plan and to ensure that the properties of the medication remain effective once crushed, mixed with food or drink and ingested. A management plan had not been completed to confirm that this decision was in the person's best interest and the least restrictive option. Furthermore the person's care plan had not been updated to reflect the GP's decision as this still referred to the person being able to take their tablets when given to them on a spoon.

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

Since March 2016, new equipment within the kitchen and adjoining utility areas had been purchased and properly maintained. Safety checks relating to the service's gas and electricity installations were now completed and up-to-date.

The majority of people living at the service were complimentary about the quality of food and meals provided. They told us that the meals provided were generally tasty and enjoyable. One person told us that although they had a limited diet as a result of several medical conditions, this was understood and catered for by staff. Another person told us, "The food is not too bad. It's not like home cooking but it is absolutely fine. Only one person told us that they did not enjoy the meals provided. They stated, "I'd like some good old fashioned English food. I don't like the stuff they give us."

We found that the dining experience across the service was satisfactory and the majority of people ate independently. People were supported to use suitable aids to eat and drink as independently as possible, for example, to eat their meal using a spoon and use of specialist beakers. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and positive encouragement to eat and drink was provided. Staff provided sufficient information, explanation or reminder to people about the actual meals provided. Throughout the inspection people were provided with sufficient hot and cold drinks at regular intervals.

The majority of people told us that their healthcare needs were well managed. One person told us, "I wasn't very well yesterday, they [staff] kept a closer eye on me, and kept checking how I was." Another person told us, "I have a hearing aid, and they [staff] make sure the batteries are changed when they run out, they're very good." People's care records showed that their healthcare needs were recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital and GP appointments and District Nurse.

Requires Improvement

Is the service caring?

Our findings

The majority of people told us that staff cared for them in a compassionate and understanding manner. Two people sitting together told us that the staff were very good and did not get cross with others who were sometimes very difficult to deal with. Another person told us, "I'm treated very well by them all [staff]. They're carers, and they do care." A visiting relative told us, "There's been a lot of staff changes recently, all of them have been good. I've never seen, or heard, anything other than good patient care." However, one person became distressed when asked for their opinion about the service. They told us, "I don't feel that they [staff] listen to me, I feel they don't really care. I just want somebody to spend time with me. I feel like a prisoner here." This person was observed on both days of the inspection to sit in the dining room with very little interaction provided from staff. Furthermore, our findings in terms of how staff supported people to ensure their well-being and support functions including care records and management support did not concur with people's comments about a caring service. The service needed to improve the way they delivered personalised care to people so as to ensure it was suitable. This was hindered by the provider's existing staffing levels and poor deployment of staff.

There was little or no evidence to indicate that people using the service or those acting on their behalf had been involved in the care planning process or consulted.

People were encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities. For example, several people at lunchtime were supported to maintain their independence to eat their meal and some people confirmed that they were able to manage some aspects of their personal care with limited staff support. Two people following assistance by staff to access the garden were seen to be able to occupy themselves. They were observed to chat with one another, to read a newspaper or book and to enjoy the good weather.

People told us that they were treated with respect and dignity. Our observations showed that staff respected people's privacy and dignity, such as, we saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to wear clothes they liked and that suited their individual needs.

The registered manager told us that where some people did not have family or friends to support them, arrangements could be made for them to receive support from a local advocacy service. People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 29 and 31 March 2016 we found that people using the service had not always received care and support from staff that was responsive to their needs or carried out in a person centred way. Although formal arrangements were in place to assess people's needs prior to admission, these had not always been conducted. Inconsistencies were evident in people's care records and not all of a person's care and support needs were identified. Significant improvements were needed for people to lead meaningful lives and to have regular opportunities to participate in social activities. The service's arrangements for complaints was poor and improvements were required. We asked the provider to send us an action plan which outlined the actions they would take to make the necessary improvements. In response, the provider shared with us on 30 August 2016 their action plan detailing their progress to meet regulatory requirements. We found that not all of the improvements had been made and/or sustained to an appropriate standard.

Significant improvements were still needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and according to their abilities. It was evident from our observations and from information recorded within people's care plans that their social care needs were not being met. Care plans relating to social activities were inadequate. Although they provided information relating to people's personal preferences they did not provide the relevant detail about how this was to be delivered by staff and some of the information appeared uniform and generic.

People's comments about social activities provided were unfavourable. One person told us, "There's not much going on. There used to be a man who visited playing his ukulele, also flower arranging and bingo. None of that's happened for a long time." Another two people told us, "We used to have entertainment, but it's stopped. People came in and we did flower arranging but it doesn't happen anymore. We would like to go out to the seafront for a coffee but we haven't got anyone to take us out." Both people told us they were disappointed that arrangements were not made for them and others to go to the local shops, the gardens or the cliffs, particularly as they were easily accessible from the service's location. One person further stated, "One of the reasons I came here was because it was so convenient for walks out, but they [staff] don't have time to do it." One relative confirmed the above. They told us, "I don't see any stimulation going on. I come in to see my relative, and we sit in their room listening to their favourite music, but what about those without relatives?"

The registered manager confirmed that since 25 July 2016 the service had been without an activities co-ordinator. In the interim the registered manager stated that staff had been asked to provide meaningful activities and social stimulation for people using the service. Despite this instruction our observations throughout the two day inspection showed that there were few opportunities provided for people to join in. For example, there was an over reliance on the use of the television and radio in communal areas and we observed long periods of inactivity where people were either asleep or disengaged with their surroundings and the people they lived with. The above was despite several people's care plans detailing, '[name of person] is at risk of boredom if they have nothing to stimulate them.'

Our inspection highlighted that people did not always receive care that was responsive to their needs or care that was carried out in a person centred way. As already highlighted within the main text of this report, this was because staff shortages at times and poor deployment of staff meant that staff's approach was primarily task focused and routine based rather than person-centred. Whilst we observed that some staff interactions with people were positive and staff had a good rapport with the people they supported, this was in contrast to other observations. These showed that some staff's practice required improvement and development. For example, staff did not always pick up on people's non-verbal communication, such as, gestures or facial expressions, where people spoke quietly or where people were unable to find the right words to communicate their needs.

We were unable to determine if appropriate arrangements were in place to assess the needs of people prior to admission as following the last inspection a restriction had been imposed by the CQC preventing admissions to the service for people's safety. At this inspection the external consultant confirmed that they had been given the responsibility by the provider to review and rewrite people's care plans. Although some people's care plans provided sufficient detail to give staff the information they needed to provide care and support, others were not as fully reflective or accurate of people's care needs as they should be. This meant that there was a risk that relevant information was not captured for use by other care staff and professionals or provided sufficient evidence to show that appropriate care was being provided and delivered. For example, where people were assessed as living with dementia, information relating to how this affected all activities of their daily living were not clearly recorded. Not all information recorded was accurate to reflect people's current care and support needs.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for becoming anxious and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had all of the information required to support the person appropriately and to reduce their anxiety.

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were made aware of changes in people's needs through handover meetings, discussions with senior members of staff and the registered manager. Staff told us that handover meetings were undertaken between each shift and were important in making sure that they had up-to-date information each day about people who used the service.

People spoken with knew how to make a complaint and who to complain to. Most people told us that they would feel able to raise any concerns, or make a complaint by speaking to staff or the registered manager. One person told us that they would in the first instance speak to a senior member of staff who they got on particularly well with. One person told us, "If I've got any problems I'll speak to the manager, they're always happy to speak to us, and will ask us if everything is alright." However, another person told us that they did not feel they could raise any concerns as they did not think anybody would listen to them, or take them seriously. Information on how to make a complaint was available for people to access. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. The registered manager advised that no complaints had been made at Melrose House since our last inspection in March 2016. On review of the service's complaints log this confirmed what the registered manager had told us.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 29 and 31 March 2016 we found that the provider's quality assurance systems were not effective or robust and there was a lack of managerial oversight of the service as a whole. This meant that the service was not effectively being run for the benefit of the people using the service. As a result of our concerns the Care Quality Commission issued an urgent Notice of Decision to restrict admissions to the service. We asked the provider to send us an action plan which outlined the actions they would take to make the necessary improvements. In response, the provider shared with us on 30 August 2016 their action plan detailing their progress to meet regulatory requirements. We found that the majority of the improvements t had not been made and/or sustained to an appropriate standard.

At the time of our inspection the provider had failed to display their performance rating following the publication of their last inspection report and despite guidance being readily available on the Care Quality Commission's website. This refers to a requirement for all providers to display their Care Quality Commission performance rating at their registered service. This is to provide transparency and a clear statement to people using the service and others about the quality and safety of the care provided. We discussed this with the provider and registered manager and they confirmed that they were unaware that the above should be displayed. An attempt was made by the external consultant to download and print the poster from our website so as to display their rating. However, this was unsuccessful and a copy of the front page of the published report was taped to the wall in reception.

We found that the provider's quality assurance arrangements and processes which assessed, monitored or improved the quality of the service continued to be ineffective. Although substantial improvements had been made since March 2016 to address our previous concerns relating to the service's kitchen, adjoining utility area and issues relating to the service's hot water supply, the provider was not able to demonstrate how they evaluated and sought to improve other elements of their governance and auditing procedures so as to comply with all regulatory requirements. The provider told us they did not have suitable formal arrangements in place to make sure this happened. For example, the provider confirmed that they did not have any formal appropriate system in place to gather and record information about the quality and safety of the care and support the service provided. When asked as to how the provider monitored what was happening in their service and how they could assure themselves that the registered manager and external consultant were ensuring the service was compliant with regulatory requirements, the provider stated that they directly asked them. The provider confirmed that they had been given verbal assurances by both the registered manager and external consultant that, "Everything is OK and fine." This meant that the provider did not have effective arrangements in place to check and ensure the service was being effectively run on a day-to-day basis, to identify non-compliance, or any risk of non-compliance with regulatory requirements.

The registered manager advised us that audits were carried out by them at regular intervals. These solely related to infection control and medication audits. However, these arrangements were not effective or robust and had not identified the issues we found during our inspection, in particular where people were placed at risk of harm or where their health and wellbeing was compromised. There was evidence to show

that because of this people did not always experience positive care outcomes and the lack of robust quality monitoring meant that there was a lack of consistency in how well the service was managed and led. Where clinical based data had been collated, these related to people's falls and weight loss and gain.

Records relating to staff employed and people using the service were not properly maintained. Although the provider had delegated the responsibility of staff recruitment and selection, training and development and care planning to another person, namely the external consultant, nothing had been put in place to determine whether this had been done properly or not. There was no evidence to show that progress to ensure compliance with regulatory requirements had been discussed and monitored between the provider and external consultant so as to demonstrate if the above arrangements were effective. Proper arrangements were not in place to ensure that effective staff recruitment and selection procedures were in place for the protection of people living at the service and that staff received a robust induction. Monitoring of staff training and how effective this was had not been checked to ensure that it was appropriate and safe for people using the service. The provider did not have an effective system in place to review staffing levels so as to determine that the deployment of staff was suitable to meet people's needs.
Care plans were basic and not all risks relating to people using the service had been identified and strategies relating to how these would be managed so as to mitigate future risk were not in place.

Suitable measures were not in place to ensure that staff were appropriately supervised. Supervisory support arrangements were poor and had not been monitored by the provider to ensure that these were effective. Additionally, proper systems were not in place to enable the effective upkeep of staffing levels or staff deployment and it was evident that there were ineffectual procedures in place to respond to unexpected changes in circumstance, for example, to cover staff sickness, absences and unforeseen emergencies.

Suitable arrangements were not in place to protect people from the risk of harm from inappropriate equipment that was not suitable or comfortable to meet their needs. This specifically related to wheelchairs used to transfer people from one place to another. Staff told us that the issues relating to there being insufficient wheelchairs to meet peoples' needs and poorly maintained wheelchairs had been relayed to the registered manager on several occasions. The registered manager confirmed that this was accurate. Infection control audits for the period April 2016 to August 2016 inclusive recorded that the service's wheelchairs and footplates were not visibly clean or in good working condition. The action plan documented that this was 'on-going,' that a member of staff was to be allocated to check and mend the wheelchairs and that the provider had been informed of the actions required. It was evident at this inspection that the infection control audit was ineffective as the actions relating to the above over a five month period had not been addressed and remained outstanding until we intervened. This showed that the provider and registered manager were reactive rather than proactive. No rationale was provided by the registered manager as to why this had not been completed sooner. Where other areas were identified for action on the infection control audit, it was not possible to determine if these had been addressed or remained outstanding as no information was recorded.

In addition, steps had not been taken by the provider or registered manager to ensure that premises was properly maintained. This specifically related to window restrictors. The registered manager confirmed that a health and safety audit of the service was not undertaken and this had not been discussed or considered. Although a maintenance log was maintained the last entries recorded were for June 2016. The registered manager confirmed that a maintenance log was not maintained to provide an audit trail of works requested, completed or which remained outstanding.

It was evident that the absence of robust quality monitoring meant that the provider and registered manager had failed to recognise any risk of harm to people or non-compliance with regulatory requirements

sooner. Had there been a more effective quality assurance and governance process in place, this would have identified the issues we identified during our inspection. It was apparent that the provider's action plan did not accurately reflect the current status of compliance with regulatory requirements.

Staff felt that the overall culture across the service was not open and inclusive. Staff told us that communication between staff and the registered manager was poor, cautious and distrusting. Staff told us that 'staff morale' was not good and this primarily related to a lack of support provided by the registered manager and those feeling not listened to and feeling that the registered manager was ineffective in their role. The feeling of unrest and low 'staff morale' was recorded in the staff meeting minutes of 11 July 2016. However, there was no information recorded as to how this would be monitored in the short and longer term, information relating to the support staff would receive and the actions to be taken for the future. Equally, the registered manager told us that they felt undermined and weakened by the attendance of the external consultant and that they were unable to establish a good working relationship with staff and to build up positive relationships. Staff told us that they did not feel able to go to the provider as they rarely saw them, did not have the confidence to approach them and felt that they were ineffective to modify change.

Staff meetings had been held at regular intervals since our last inspection in March 2016 so as to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service. Although a record had been maintained, where matters were highlighted for action or monitoring, it was not possible to determine if these had been addressed or remained outstanding. Meetings for people who used the service had been conducted each month since March 2016. One person told us, "We have regular meetings in the big lounge. The manager talks to us about what's going on, it's very helpful. It gives us a chance to say how we feel about things."

Because of these continued failings the service remains in special measures with a continued rating of inadequate. We have initiated enforcement action against the provider.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider confirmed that the views of people who used the service, those acting on their behalf and others had been sought and responses returned to the registered manager at the end of August 2016. Comments about the quality of the service were variable. People spoke positively about staff and the quality of care provided. Where negative comments were recorded these related to the general decoration and appearance of the service and lack of activities and social stimulation for people using the service. A report and subsequent action plan had not been collated as the responses had only just been received at the service.

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 Assessments of people's care did not include all of their care and support needs. People's preferences were not being met in relation to how their social care needs were to be met.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all care and treatment was provided in a safe way for people using the service. Risks were not always mitigated to ensure people's safety and medicines management was not effective.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration ancellation of registration

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 People using the service were not protected from abuse and improper treatment. Suitable measures were not in place to safeguard people and protect them from abuse.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not supported by the providers systems and processes to assess and

	monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety was compromised.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected by the provider's recruitment procedures.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the registered provider had not ensured that there were sufficient numbers of staff deployed so as to make sure that they can meet people's care and treatment needs. The provider had not ensured that staff received appropriate learning and development needs that supported them to fulfil the requirements of their role to meet people's needs. Staff had not received on-going or periodic supervision.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration