M Rashid

Melrose House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

At a previous unannounced comprehensive inspection of this service carried out on 7, 13 and 14 March 2017 we found breaches with regulatory requirements relating to Regulation 9 [Person centred care], Regulation 10 [Dignity and respect], Regulation 12 [Safe care and treatment], Regulation 13 [Safeguarding service users from abuse and improper treatment], Regulation 15 [Premises and equipment], Regulation 17 [Good governance] and Regulation 18 [Staffing]. As a result of our concerns the Care Quality Commission took action in response to our findings by rating the service as 'Inadequate' and placing the service back into 'Special Measures.' Following the inspection action was taken to cancel the registered manager's registration.

We asked the registered provider to send us an action plan which outlined the actions they would take to make the necessary improvements. In response, the registered provider shared with us their action plan at regular intervals between August and September 2017detailing their progress to meet regulatory requirements and to achieve compliance with the fundamental standards. At this inspection some considerable progress had been made to meet regulatory requirements, however further improvements were still required, in particular relating to the registered provider's quality assurance and governance arrangements.

The overall rating for this service is 'Requires Improvement.' However, we are placing the service in 'Special Measures.' We do this when services have been rated as 'inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

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

This inspection was completed on 19 and 20 September 2017. There were 18 people living at the service when we inspected.

A registered manager was not in post at the time of this inspection. The service was being managed by a team leader as the manager who had been appointed in May 2017 had left the service prior to our inspection. 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.

Whilst improvements were noted since our last inspection in relation to some aspects of care provision, for example, care planning arrangements, medicines management, ensuring that bedrails for people using the service were now safe and fit for purpose, pressure relieving equipment was set correctly and infection control practices were now effective; quality assurance arrangements at provider and service level were not

robust or as effective as they should be.

There was a lack of oversight by the registered provider to check and monitor the quality of the service provided or to check that the manager was making progress to the action plan so as to achieve compliance with regulatory requirements. It was evident from our findings at this inspection and following discussions with the registered provider that they had relied heavily on the manager to provide them with reassurance about their progress. Although the registered provider was told not to worry and everything was in hand, the registered provider had failed to monitor and evaluate this progress properly so as to assure themselves that sufficient improvements had been undertaken to their audit and governance arrangements and these were effective.

Robust procedures and processes that make sure people are protected from abuse and improper treatment had not been considered and followed by the manager. There had been a lack of preventative actions undertaken by the manager to keep people safe and to ensure that where there were concerns about a member of staff's conduct appropriate actions were taken. We found that neither the registered provider, manager or staff fully understood their associated responsibilities and role in relation to preventing abuse of people using the service and to keep them safe.

Staff were aware of people's individual risks and control measures to mitigate future risk had been explored and considered. However, improvements were needed to ensure the service's fire risk assessment was updated and people's individual emergency evacuation plans were accessible in the event of a fire or other emergency.

Training for newly employed staff was not up-to-date and it was difficult to determine what training had been attained by others employed at the service as certificates and evidence of training previously achieved was no longer available. Although staff stated they felt supported by the team leader, newly employed staff had not received a robust induction and staff had not received formal supervision.

Whilst some improvements were noted to the premises, further improvements were still required to maximise the suitability of the premises for the benefit of people living with dementia. This referred specifically to there being limited signage available to help people to orientate themselves around the service and there was a lack of sensory stimuli, such as orientation boards, information in an easy to understand format and memory boxes to help aid reminiscence.

Although all people using the service had a care plan in place, not all care plans had been reviewed and updated to accurately reflect people's current care needs and improvements were required. Whilst people enjoyed a variety of 'in house' activities, improvements were needed to ensure that people living at the service had the opportunity to access their local community.

The deployment of staff was observed to be appropriate and there were sufficient staff available to meet people's needs to an appropriate standard throughout the day and night. Part of this inspection was completed out of hours to ensure night staffing levels were appropriate. Suitable recruitment practices were in place and being followed so as to keep people safe. We observed that staff followed safe procedures when giving people their medicines and records now showed that people received their medicines as prescribed.

Staff had a basic knowledge of the Deprivation of Liberty Safeguards [DoLS] and the key requirements of the Mental Capacity Act [2005]. However, people were routinely asked to give their consent to their care, treatment and support by staff and people's capacity to make day-to-day decisions had been considered

and assessed.

People were supported to have enough to eat and drink. Suitable arrangements were in place to monitor and record people's nutritional and hydration intake so as to identify at the earliest opportunity those people who were at risk. People received appropriate support where they required assistance to eat and drink. People were supported to maintain their healthcare needs and had access to healthcare services as and when required.

Staff knew the care needs of the people they supported and people told us that staff were kind and caring. Staff responded to people's need for support and demonstrated appropriate concern for their wellbeing and people told us they were happy with the care and support provided by staff. People and their relatives told us that if they had any concerns they would discuss these with the management team or staff on duty. People were confident that their complaints or concerns were listened to, taken seriously and acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Robust arrangements were not in place to protect people from abuse and improper treatment.

Staff were aware of people's individual risks and control measures to mitigate future risk had been considered. However, improvements were needed to ensure the service's fire risk assessment is updated and people's emergency evacuation plans accessible.

Medicines management arrangements were now suitable.

The deployment of staff was suitable to meet people's care and support needs. Suitable procedures were in place to recruit staff safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Recommended training for newly employed staff was not up-to-date and it was difficult to determine what training had been attained by others employed at the service.

Although staff stated they felt supported by the team leader, newly employed staff had not received an induction. Staff had not received formal supervision.

Whilst some improvements noted to the premises, further improvements were still required to maximise the suitability of the premises for the benefit of people living with dementia.

Staff supported people to meet their nutritional needs. People were supported to access healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The service had not shown a caring approach as not all people using the service had been protected from abuse or improper treatment.

Interactions between staff and people using the service were positive.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all care plans had been reviewed and updated to accurately reflect people's current care needs and improvements were required.

Whilst people enjoyed the 'in house' activities provided, improvements were needed to ensure that people living at the service had the opportunity for community access.

Appropriate arrangements were in place for people to give their views and to raise concerns or complaints. People were confident that their complaints would be listened to, taken seriously and acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

Quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance and to help drive improvement.

There was a lack of oversight by the registered provider to monitor progress to their action plan.

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

This inspection took place on 19 and 20 September 2017 and was unannounced. The inspection team consisted of two inspectors.

We reviewed information that we hold about the service such as safeguarding information and notifications. Notifications are the events happening in the service that the provider is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

During the inspection, 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 six people who used the service, two people's relatives, five members of staff, the team leader and the registered provider. We reviewed six people's care files, four staff recruitment files and staff training and supervision records. We also looked at the service's arrangements for the management of medicines, complaints and compliments, information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection to the service on 7, 13 and 14 March 2017, we found that not all risks were identified or appropriately managed or mitigated to ensure people's safety and wellbeing. Additionally, the management of medicines was not safe as people did not always receive their medication as prescribed and medicines were not stored as safely as they should be. The safekeeping of people's money was not appropriate as the procedures and processes relating to the financial management of peoples monies were not protected or safeguarded. The registered provider had shared with us their action plan at regular intervals and this provided detail on their progress to meet the required improvements. At this inspection we found that the required improvements in relation to the above had been made.

Staff were verbally able to demonstrate an understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Staff confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission without hesitation if they felt their concerns were not addressed or taken seriously by the manager or registered provider. While the above was positive we found that the latter had not always happened in practice and improvements were required to ensure people using the service were protected from harm and potential abuse.

During the inspection video material taken by a member of staff was shown to us. This revealed an incident whereby a person using the service was not able to exit the main passenger lift as their access was restricted by a member of staff and they were ridiculed by the same staff member. Although the manager dismissed the member of staff and a safeguarding alert was generated, the latter was not forwarded to the Local Authority or Care Quality Commission. There was no evidence to demonstrate actions taken, for example, speaking to the person using the service so as to provide support and reassurance following the incident and there was no evidence to demonstrate an internal investigation had been initiated and conducted by the manager. Although disciplinary action had been taken relating to the member of staff's conduct there was no evidence to demonstrate the member of staff had been referred to the Disclosure and Barring Service to be considered and placed on the barring list. On review of the safeguarding alert provided at the time of the inspection, this recorded the manager was not made aware of the incident until nine days later. This demonstrated that staff did not fully understand their associated responsibilities and role in relation to preventing abuse of people using the service at the earliest opportunity.

We found that following concerns about one member of staff's conduct whilst still employed at the service, robust procedures and processes that make sure people are protected from abuse and harm had not been considered and followed by the manager of Melrose House. The manager had failed to follow and implement robust safeguarding procedures that make sure people are protected. The Local Authority and Care Quality Commission had not been notified in relation to a person using the service receiving care and support that was rough and forceful. There was no evidence to demonstrate actions taken, for example, speaking to the person using the service so as to provide support and reassurance and there was no evidence to demonstrate an internal investigation had been initiated and conducted by the manager. We discussed this with the team leader and they confirmed no further action had been taken by the manager to address the above. It was apparent that the team leader and other senior members of staff employed at the

service had been aware of the manager's lack of action in this matter, however no-one had thought to notify the Local Authority or Care Quality Commission. We also discussed this with the registered provider. They confirmed they were aware of the above issues but were dismissive of the concerns raised.

Our findings showed there had been a lack of preventative actions undertaken by the manager to keep people safe and to ensure that the member of staff concerned did not repeat previously known poor care practices dating back to 2015. No management plan had been put in place to monitor the member of staff's performance so as to ensure people were protected from abuse and improper treatment. This also demonstrated that neither the manager nor the registered provider fully understood their associated responsibilities and role in relation to preventing abuse of people using the service and to keep them safe.

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

The registered provider's action plan dated 1 September 2017 stated that a review of the arrangements for the safekeeping of people's money would be undertaken. A review of five people's money was checked as part of this inspection. We found the procedures and processes relating to the financial management of people's monies were now protected and safeguarded.

We asked people whether they felt safe living at the service. People confirmed to us that staff looked after them well, their safety was maintained and they had no anxieties or worries. One person told us, "I feel very safe here. It's [the care home] is well-run, I know where to go if I have any complaints." Another person told us, "The staff make me feel safe, they [staff] are always around checking on us."

Staff knew the people they supported and were aware of people's individual risks and how these could impact on a person's health and wellbeing. The majority of risks had been identified and control measures had been considered and put in place to mitigate the risk or potential risk of harm for people using the service. These assessments covered a range of risks, such as the risk of poor nutrition and hydration, poor mobility and falls, the risk of developing pressure ulcers and moisture lesions and people at risk of choking. Our observations showed that staff's practice reflected that risks to people were being managed so as to ensure their wellbeing and to help keep people as safe as possible. The team leader was advised that minor improvements were required to ensure one person's risk assessment relating to their 'skin integrity' was updated to reflect their current status. Additionally, no risk assessment had been completed for one person who self administered their own medication. We discussed this with a senior member of staff and they confirmed that the manager had agreed to undertake the latter with the person using the service, however this remained outstanding. This is important to make sure the person remains competent and able to undertake this task safely.

Environmental risk assessments to ensure people's and staff's safety and wellbeing were in place. For example, those relating to the service's fire arrangements. The team leader confirmed that appropriate fire detection, warning systems and fire fighting equipment were in place and checked to ensure they remained effective. The team leader told us that fire drills within the service were regularly undertaken and records confirmed this as accurate. Additionally, the team leader confirmed individual Personal Emergency Evacuation Plans (PEEP) had been completed for people living at the service. This is a bespoke plan intended to identify those who are not able to evacuate or reach a place of safety unaided in the event of an emergency. These were kept within people's individual care plan and had not yet been photocopied and placed within the service's 'grab bag' for staff to access in the event of a fire or other major incident. We discussed this with staff and not all staff were aware of the location of the 'grab bag'. A fire risk assessment had been completed in March 2017 by the previous registered manager. However, the registered provider's

action plan dated 1 September 2017 recorded that an updated 'fire safety risk assessment' would be completed by 30 June 2017. At the time of this inspection there was no evidence available to suggest this had been updated and completed as stated.

Prior to our inspection concerns were raised that staffing levels at the service were not appropriate, particularly at night between 9.00 p.m. and 8.00 a.m. People told us that staffing levels at the service were appropriate in meeting their needs both during the day and at night. One person told us they received the help they needed in a timely manner. They told us, "If I need help the staff are there." Another person told us, "I think there are enough staff. I do not have any issues." A third person told us, "There are always enough staff around." Our observations indicated the deployment of staff was suitable to meet people's needs throughout the day and at night. We saw that staff were attentive to people's needs and requests for assistance were responded to promptly.

Staff recruitment records for three members of staff appointed since March 2017 showed the manager had operated safe recruitment practices in line with regulatory requirements. Relevant checks had been carried out by the manager before a new member of staff commenced working at the service. These included the completion of an application form, attainment of references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS]. Furthermore, a record of the interview process had been completed and maintained. However, the manager's recruitment file could not be located at the time of the inspection despite the registered provider and team leader contacting the manager during the inspection.

Medicines were stored safely for the protection of people who used the service. Our observation of staff practice in relation to the administration of medication for people using the service was good and staff were seen to undertake this task with both dignity and respect for the people they supported. However, on two occasions whilst a senior member of staff administered medication to people using the service in the dining room the doors to the medication trolley were left open. This meant that medicines were available to people not authorised to have access and left people at risk of potential harm. This was brought to the team leader's attention as soon as was practicable. An assurance was provided by them that they would discuss the issue with the senior member of staff and all seniors would be reminded of the importance of ensuring medicines were stored safely. No concerns were highlighted on the second day of inspection.

Comments about the provider's medication arrangements from people using the service were positive, as people confirmed they received their medication as they should. People received their medication in a timely manner as the medication rounds were evenly spaced out throughout the day to ensure that people did not receive their medication too close together or too late. Suitable arrangements were in place to record when medicines were received into the service, given to people and disposed of. We looked at the Medication Administration Records [MAR] for nine out of 18 people living at the service. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. Where people were prescribed medication dependent on the results of a blood test, for example Warfarin, information relating to this was kept with the MAR form and specific instructions and adjustments relating to the dose of this medication were followed.

Requires Improvement

Is the service effective?

Our findings

At our previous comprehensive inspection to the service on 7, 13 and 14 March 2017, we found that not all staff had received a robust induction for their relevant role. Staff did not always understand the importance of giving people choices and respecting their wishes and the premises were not fit for purpose, particularly for people living with dementia. The registered provider had shared with us their action plan at regular intervals and this provided detail on their progress to meet the required improvements. At this inspection we found that not all of the required improvements had been made.

Staff training records viewed for three members of staff employed since March 2017 confirmed the registered provider's recommended training was not up-to-date. For example, the personnel file for two members of staff employed in July and August 2017 provided no evidence of specific training either previously attained when employed at their last employer or subsequently undertaken since being employed at Melrose House. Furthermore, the personnel file for one member of staff employed since May 2017 showed training completed related to health and safety, fire awareness, Control of Substances Hazardous to Health [COSHH], food hygiene and manual handling. Information, guidance and instruction relating to bed rails and catheter care had been provided by the manager in June and July 2017. The personnel files for two members of staff employed longer than 12 months at the service were also viewed. Evidence of training completed other than guidance and instruction relating to bed rails, catheter care and fire awareness were no longer available within their personnel files. Neither member of staff was aware that this information had been taken out of their file or where it had gone. A copy of the staff training matrix was requested. Although a training matrix template was devised and forwarded to the manager and registered provider by the external consultant on 4 September 2017, at the time of the inspection the document was blank.

No records were available to show that newly employed staff had completed an 'in-house' orientation induction. Improvements were also required to ensure the 'Care Certificate' or equivalent was completed, particularly where staff had limited experience working within a care setting and did not have a National Vocational Qualification at Level 2 or above. The latter referred to two out of three newly employed members of staff employed since March 2017. Additionally, where staff had been promoted they had not received a comprehensive induction for their designated role. This referred specifically to the newly appointed team leader and a senior member of staff. The latter when asked as to what their induction entailed told us they 'shadowed' the manager and team leader when administering medication to people using the service and when they made telephone calls.

Although staff told us they felt supported by the team leader following the manager's recent departure from the service, formal supervision arrangements as detailed within the registered provider's action plan had not been completed for senior members of staff. The action plan detailed that all senior team members would receive supervision by 15 September 2017. Records showed that formal supervision arrangements were last completed in December 2016 and February 2017 respectively and by the previous registered manager. Staff newly employed in May 2017 and July 2017 had also not received formal supervision. This was confirmed by staff spoken with as accurate.

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

Although some improvements were noted in relation to the premises, for example, the dining room had been newly decorated and refurbished, curtains hung properly and lighting within all areas of the service were now working; further improvements were still required to maximise the suitability of the premises for the benefit of people living with dementia. This referred to signage to help people to orientate themselves within the building and the introduction of sensory stimuli, such as, orientation boards and memory boxes to help aid reminiscence.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Care records identified people's capacity to make day-to-day decisions, however not all care plans had been signed by people using the service or those acting on their behalf to show they had consented to their care and had been involved in their care planning. Where people had appointed persons with lasting power of attorney [LPA], copies of authorised LPA's had now been sought and held on file.

Not all staff had been provided with training in MCA and DoLS, however the majority of staff were able to demonstrate a basic knowledge and understanding of these principles and how to apply these. We saw that staff sought people's consent before they provided any support or care. People were observed being offered choices throughout the day. People told us they could choose what time they got up in the morning and the time they retired to bed each day, what items of clothing they wished to wear, whether they required PRN 'as and when required' pain relief medication, where they ate their meals and whether or not they wished to participate in social activities. This meant we were assured that staff understood the importance of giving people choices and respecting their wishes.

People were positive about the meals provided. One person told us, "The food here is very good, I have no complaints." Another person told us, "The meals are very tasty. I eat everything they [staff] give me." A third person told us, "The food is good, I can't grumble."

The dining experience was noted to be relaxed. At lunchtime we saw that the meals were nicely presented and staff were seen to encourage people to eat independently according to their needs and abilities. One staff member was overheard to say to one person, "That is your fork and that is your knife." The person then began to eat, however it was evident over time that they were struggling and a spoon was also offered. Where people required assistance and support to eat and drink this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and were able to enjoy the dining experience at their own pace. There was lots of discussion and staff were chatting to people, checking they were happy and enjoying their food.

People told us their healthcare needs were well managed. Relatives confirmed they were kept informed of their member of family's healthcare needs and the outcome of any healthcare appointments. Care records

showed that minor improvements were needed to ensure people's healthcare needs were clearly recorded, including 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 appointments, see a GP, District Nurse or Community Psychiatric Nurse.

Requires Improvement

Is the service caring?

Our findings

At our previous comprehensive inspection to the service on 7, 13 and 14 March 2017, we found that although people were complimentary about the care and support provided, observations showed that people did not consistently receive a service that was caring. Staff did not always respect people's dignity or treat them with respect. The registered provider had shared with us their action plan at regular intervals and this provided detail on their progress to meet the required improvements. At this inspection we found that the required improvements had been made and the care and support provided for people using the service was much better.

Overall people and their relatives told us that staff cared for people in a caring and kind way. Our overall findings however, in terms of potential risks to people's safety and wellbeing, as well as all support functions including care records and management oversight, did not concur with people's comments about a caring service. This referred specifically to not all people using the service being protected from abuse or harm, not all staff were aware of the location of the 'grab bag' for in the event of a fire or other major incident, training for some staff was not up-to-date and staff had not received a robust induction.

People were satisfied and happy with the care and support they received. One person told us, "I am very happy here. I couldn't have asked for a better place to live. I am very lucky to be in a place like this. It's a hard job being a carer, but the girls [staff] do their best for us." Another person told us, "I really like it here, the staff are good and always kind to me." A third person stated, "I would rather be in my own home, but the staff do their best. [Name of member of staff] is my favourite and she is lovely and kind." One relative told us, "The staff have a caring and loving attitude. I believe my relatives receive a good level of care and I am personally impressed with the level of care and support they receive."

We observed that staff interactions with people were positive. The atmosphere within the service was seen to be very relaxed, calm and friendly throughout the inspection. Staff were noted to have a good relationship and rapport with the people they supported and there was much good humoured banter during the inspection which people enjoyed and appreciated.

Staff understood people's care and support needs and the things that were important to them in their lives, for example, members of their family and their individual personal preferences. People were encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their capabilities and strengths. For example, where appropriate people were encouraged to maintain their independence with eating and drinking and with some aspects of their personal care. One person told us, "Some mornings when I am not feeling well the staff will get me washed and dressed but most days I am independent."

Staff were able to verbally give good examples of what dignity meant to them, for example, knocking on doors, keeping the door and curtains closed during personal care and providing explanations to people about the care and support to be provided. Our observations showed that staff respected people's privacy and dignity. Staff were observed to use the term of address favoured by the individual. In addition, we saw

that people were supported to maintain their personal appearance so as to ensure their self-esteem and sense of self-worth. People were supported to wear clothes that they liked, that suited their individual needs, were colour co-ordinated, including jewellery and were appropriate to the occasion and time of year.

People were supported to maintain relationships with others. People told us their relatives and those acting on their behalf were able to visit them at any time. Relatives confirmed there were no restrictions when they visited and that they were always made to feel welcome by the staff team and could stay as long as they wanted.

Requires Improvement

Is the service responsive?

Our findings

At our previous comprehensive inspection to the service on 7, 13 and 14 March 2017, we found that not all people who used the service had a full care plan in place to detail their care and support needs and not all care plans were sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff. Whilst 'in house' activities were provided, improvements were needed to enable people to access the local community. The registered provider had shared with us their action plan at regular intervals and this provided detail on their progress to meet the required improvements. At this inspection, although good progress had been made, further improvements were still required.

During the inspection we saw that staff clearly knew the people in their care and were aware of what they needed to do to ensure they responded to people's care needs. However, whilst people's care plans provided an overview of a person's needs, where changes relating to their care had occurred these had not always been updated to accurately reflect their current needs. For example, the service's communication book recorded one person as having developed a pressure ulcer eight days prior to our inspection. The person's care plan had not been updated to reflect this and how this was to be effectively managed, including healthcare interventions and the advice to be followed by care staff. Another person's daily care notes also made reference to them developing redness and experiencing poor skin integrity. Although action was taken to seek healthcare interventions, the person's care plan had not been updated to accurately reflect their current care needs. Furthermore, a formal risk assessment tool used to identify people who are at risk of developing pressure ulcers had not been updated and reviewed since July 2017. Although staff knew both people and were able to tell us exactly what they would do to support them, newly employed staff or staff from an external agency would not know how to support these people from reading their care plans.

We discussed the above with the team leader and they confirmed that the majority of peoples' care plans had been reviewed and updated. However, they were aware that further work was still required and six care plans required reviewing. The team leader stated that staff were doing their utmost to write the care plans in a person-centred way so as to ensure they contained all of the information necessary relating to a person's care and support needs. Nonetheless, the team leader told us that staff were finding the process hard as they had received limited care planning training.

People's comments about the social activities provided at the service were positive, however this related to the provision of 'in house' activities. One person told us, "I join in with activities when I can." When asked if they were able to access the local community, the person told us that the last time they had been supported to go out was for 'Remembrance' Service in November 2016. Another person told us they were not bothered about taking part with 'in house' activities but stated they would like to go out more particularly as the service was in close proximity to the town centre and to the seafront. One person's care records made reference to them accessing the local community at least once a week. However, records viewed showed they had last accessed the local community in June 2017 when they were supported to walk to the park.

During both days of the inspection people were able to watch television, some people listened to music,

others read a book, newspaper or magazine, some people did some colouring whilst others played games or knitted. On the second day of inspection people did more of the above, however in the afternoon people enjoyed a visit from an external entertainer who sang a variety of well known songs and who also provided religious observance. People were very animated and engaged with the afternoon's entertainment. People confirmed they had very much enjoyed the activity.

We found that suitable arrangements were in place for people if they had a concern or were not happy with the service provided to them. People spoken with confirmed they knew who to approach if they had any concerns or complaints. People told us if they were not happy, they would not hesitate to talk to the staff or a member of their family. People told us they had not had the need to raise any concerns.

Inadequate

Is the service well-led?

Our findings

At our previous comprehensive inspection to the service on 7, 13 and 14 March 2017, we found the registered provider's quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance with regulatory requirements and to help drive improvement. The registered provider had shared with us their action plan at regular intervals and this provided detail on their progress to meet the required improvements. At this inspection whilst we recognised that some progress had been made, for example relating to medicines management, ensuring that bedrails for people using the service were safe, pressure relieving equipment set correctly and infection control practices were now effective, significant improvements were still required.

Following our last inspection to the service in March 2017 and as a result of continued non-compliance with regulatory requirements, the registered manager's registration with the Care Quality Commission was cancelled. In May 2017 the registered provider appointed a new manager from an external agency to manage the day-to-day management of Melrose House. Furthermore, the registered provider employed the services of an external consultant to provide on-going support and advice to them and the new manager. However, at this inspection the manager was no longer employed at the service as they had resigned from their post shortly prior to our inspection. As a result of this the registered provider promoted a senior member of staff to the role of team leader seven days prior to this inspection so as to manage the day-to-day running of the service.

Staff spoke very highly of the team leader, stating they were thankful and appreciative that they were managing the service on a day-to-day basis, providing continuity to both staff and people using the service. However, the team leader confirmed they had received no handover from the manager prior to them leaving, received no induction to the role of team leader and had not been given a new or revised job description. The team leader verified that although they could contact the registered provider and the external consultant for advice, no other arrangements had been discussed or suggested to support them in this difficult and challenging role. They told us that although they could support the existing staff team and ensure people using the service received a good level of care to meet their needs, they were unclear of the specifics of the role and the registered provider's expectations.

We discussed the above with the registered provider. The registered provider confirmed they had been given short notice by the manager of their impending resignation and the decision to appoint the team leader in the interim gave them time to engage with an external employment agency to recruit a new manager. The registered provider confirmed at this inspection that an appointment had been made and the new manager was due to commence in post on 27 September 2017.

Since August 2017 the registered provider had sent the Care Quality Commission a fortnightly action plan detailing how they intended to meet regulatory requirements as highlighted following the last inspection in March 2017. Out of 31 points highlighted within the action plan dated 1 September 2017, our findings showed at the time of the inspection a significant number of these actions were either partially completed or not completed at all. For example, the action plan detailed that senior staff would receive supervision by

15 September 2017 and the training needs of staff would be reviewed by 31 July 2017. The team leader and senior staff spoken with confirmed supervision by the manager had not commenced or completed and the staff training matrix provided by the external consultant was blank.

The action plan recorded that a fire safety risk assessment would be reviewed and updated by 30 June 2017. At the time of the inspection an updated fire risk assessment could not be located and the team leader was unaware if this had been completed. However, it was noted that the previous fire risk assessment dated March 2017 remained in place. Additionally, the action plan recorded that the manager would undertake fire awareness training with staff and Personal Emergency Evacuation Plans (PEEP) for people using the service would be stored in a 'grab bag'. Staff confirmed that the manager had not provided fire awareness training and PEEP's had yet to be placed in the 'grab bag'. Not all staff spoken with were aware of the whereabouts of the 'grab bag' or what information it contained.

The action plan also confirmed a premises audit would be completed and a refurbishment plan for the premises devised. We discussed the refurbishment plan with the team leader and were advised that out of 16 possible areas requiring action between June and September 2017 only four of these had been completed. A revised refurbishment plan had not been completed by the manager and/or discussed with the registered provider regarding outstanding decoration and refurbishment to the premises.

Additionally, the action plan detailed that a well known pharmacy and the local NHS Clinical Commissioning Group had completed a pharmacy visit to Melrose House and provided a report of their findings. Neither report could be located at the time of the inspection and the team leader and two senior staff members had not had sight of either report. The action plan suggested there were actions from the reports to complete but it was not possible to determine what these were.

People using the service were unable to tell us if they had been asked to complete a quality assurance survey relating to Melrose House. The action plan stated these had been put in place and commenced in June 2017. No evidence to substantiate this could be found at the time of the inspection.

We discussed all of the above with the registered provider. The registered provider confirmed there were no formal arrangements in place for him to check and monitor the quality of the service provided or to check that the manager was making progress to the action plan so as to achieve compliance with regulatory requirements. Although a monthly provider report format had been devised by the external consultant and forwarded to the manager, this had not yet commenced. The registered provider advised they visited the service every day and had spoken with the manager at regular intervals. The registered provider stated they had relied on the manager to provide them with verbal reassurance about their progress with the action plan. The registered provider advised both inspectors that he was told not to worry and everything was in hand. The registered provider confirmed they had not held any formal meetings with the manager to assure themselves that sufficient improvements had been made and to discharge their responsibilities in ensuring overall effective oversight of the service.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Not all people using the service had been protected from abuse and improper treatment.

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 were compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive on-going or periodic supervision. Staff had not received a robust induction and improvements were required to ensure effective systems were in place for staff to receive training.