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Melrose Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Melrose Residential Home [Melrose] is located in a residential area of Leyland, close to the town centre. The home is on three floors, with passenger lift access. Accommodation is provided in single rooms for up to 26 adults, who need assistance with personal care. There is easy access to amenities, such as shops, supermarkets, pubs and churches. Some parking spaces are available at the front of the home and on road parking is also permitted. There are garden areas to the front and to the rear of the premises.

The last inspection of this location was conducted on 7 February 2017. An overall rating of 'Requires improvement' was awarded at that time. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at that inspection. These were in relation to person centred care, need for consent, safe care and treatment and good governance.

This inspection was unannounced, which meant that people did not know we were going to visit the home. It was initially a focused inspection undertaken on 27 June 2017, following concerns raised by the local authority safeguarding team. However, additional breaches were identified in other areas and therefore a full comprehensive inspection was undertaken. The two adult social care inspectors inspected the home again on the 30th June and 10 July 2017 to gather further evidence required, in order to complete the comprehensive inspection.

The registered manager was on duty at the time of 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 of the Health and Social Care Act and associated regulations about how the service is run.

At the last inspection we found the provider had not ensured that the care planning process always accurately reflected people's needs and was always person centred.

At this inspection we found that four people who had lived at the home for several months did not have any care plans in place and another person did not have short term care plans around recent surgical procedures. Therefore, no guidance was provided for staff about the specific needs of these people and how these needs were to be best met. These people were therefore at risk of receiving unsafe or inappropriate care and support.

At the last inspection we found that the provider had not ensured that consent to care and treatment had always been sought from people who were assessed as having the capacity to make decisions.

At this inspection we found that the provider had not sought any consent from four people who lived at the home and who had not been assessed as lacking capacity to make decisions. The consent forms for many of the other people had only been partially completed. Therefore, people were receiving care and support, which they had not formally consented to.

At the last inspection we found that the provider had not always ensured that assessments had been conducted in order to mitigate potential risks to the health, safety and welfare of those who lived at the home.

At this inspection we found that four people did not have any risk assessments in place and the provider had also failed to fully protect others who lived at the home, as the risk management process was insufficient.

We found that steps had not been taken to assess people's ongoing needs and plans of care or risk management plans had not been developed in order to keep them safe. This did not promote people's safety and therefore they were potentially at risk of harm.

At the last inspection we found that medicines were not always managed safely.

At this inspection we found the management of medicines was not robust and therefore people were at risk of medicine mismanagement.

At the last inspection we found that the provider had not ensured that effective systems had been established in order to assess and monitor the quality of service provided.

At this inspection we found that there were no effective systems in place to adequately assess and monitor the quality of service provided. Although surveys had been circulated to those who lived at the home and their relatives the auditing system was insufficient. The registered providers did not provide an oversight of the home in order to monitor the quality of service delivered. There were no meetings held between managers and providers, the staff team or for residents and their relatives, so that people could keep up to date with any changes and could discuss any topics in an open forum, should they wish to do so.

In addition to the continuous above failings we also found that recruitment practices adopted by the home were not always robust, in order to ensure that people employed were fit to work with vulnerable adults.

We found that training for the staff team was not sufficient to help them fulfil their roles in a competent and skilful manner. Supervision and appraisals for staff were not adequate to allow appropriate monitoring and support for those who worked at Melrose.

At this inspection we found the environment to be warm throughout. However, the premises were in need of updating and modernising, as the environment was looking tired and worn. We made a recommendation about this.

There were some safety issues noted during our tour of the premises, such as easy access to domestic chemicals and poor infection control practices. We noted two fire doors were propped in the open position and a third was prevented from closing by the carpet pile. This presented a fire risk for the people who lived in these rooms. Some fire records were not up to date.

People looked happy and comfortable in the presence of staff. Meals were being well managed.

The service had not always reported safeguarding concerns to the relevant authorities. Records showed that the principals of the Mental Capacity Act 2005 ad the Deprivation of Liberty Safeguards were not being sufficiently implemented and people's privacy and dignity was not consistently respected.

At the last inspection we found that systems had not been appropriately serviced or maintained, in

accordance with the manufacturer's recommendations. At this inspection we found that systems and equipment had been serviced in accordance with the manufacturer's recommendations, to ensure they were fit for use.

People we spoke with were aware of how to raise concerns, should they need to do so. A complaints procedure was in place at the home and a system had been implemented for the recording of complaints received.

People we spoke with were complementary about the staff team. They felt that they were treated in a kind, caring and respectful manner. People expressed their satisfaction about the home and the services provided.

We did not see evidence of the provision of leisure activities and people who lived at the home felt this was an area which could be improved. We made a recommendation about this.

We found multiple breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care; dignity and respect; need for consent; safe care and treatment; safeguarding service users from abuse and improper treatment; good governance; staffing and fit and proper persons employed. We also found a breach of The Care Quality Commission (Registration) Regulations 2009, in relation to notification of other incidents.

Management Review meetings were held on the 27, 30 June 2017 and 07, 10 July 2017. These were decision making processes about risk, impact and the level of concern of each of the breaches. Discussions were also held to decide how the Care Quality Commission could mitigate risks to ensure people living at Melrose Residential Home could be kept safe.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

Risks to people's health, safety and wellbeing were not appropriately assessed and medicines were being not well managed. Conflicting information was sometimes provided within the records we saw.

Safeguarding referrals had not always been made to the relevant authorities and recruitment practices adopted by the home were not robust. Therefore assurances that only suitable staff were appointed to work with the vulnerable client group were not evident.

Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations.

Is the service effective?

Inadequate

This service was not effective.

Records showed that staff received an induction when they started to work at the home. However, this was very brief. The staff team did not receive sufficient training or structured supervision and appraisals, in order to ensure continued support.

The principals of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards had not been implemented. Consent had not always been obtained.

The home was warm and meals were being well managed.

Is the service caring?

Requires Improvement

This service was not always caring.

People told us that staff were kind and caring. However, we found that people were not consistently respected.

Those who lived at the home were supported to maintain their independence, as far as possible and staff members

communicated well with those in their care.

Is the service responsive?

Inadequate

This service was not responsive.

Although pre-admission assessments had been conducted the planning of people's care was poor. Care plans had not been generated for some people who had lived at the home for several months and therefore person centred care was not provided.

People were offered some choices. However, some of those who lived at the home felt that the area of activities could be improved.

Is the service well-led?

Inadequate

This service was not well-led

There was a lack of recorded oversight by the registered provider. As such the home had not implemented methodologies for assessing and monitoring the quality of service provided.

The views of people who had an interest in the home were not regularly sought. Although surveys had been conducted, meetings for those who lived at the home, their relatives and the staff team were not arranged on a regular basis.

Recruitment practices adopted by the home were not robust and therefore assurances that only suitable staff were appointed to work with the vulnerable client group were not evident.

The relevant authorities were not notified of reportable events. We had concerns about the ability of the registered manager to operate the service in a safe and effective manner

Melrose Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider had addressed the breaches identified at the previous inspection, if they were 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 new rating for the service under the Care Act 2014.

This inspection was unannounced and was conducted by two Adult Social Care inspectors from the Care Quality Commission (CQC) and an expert by experience. An expert by experience is a person who has experience of the type of service being inspected. At the time of our inspection there were 17 people who lived at Melrose. We spoke with nine of them and two family members.

We spoke with four members of staff and the registered manager of the home. We toured the premises, viewing a selection of private accommodation and all communal areas. We observed the day-to-day activity within the home and we also looked at a wide range of records, including the care files of all 17 people who used the service. This enabled us to determine if people received the care and support they needed and if any risks to people's health and safety were being appropriately managed.

We also looked at the personnel records of three staff members, which helped us to establish the robustness of recruitment practices and the level of training provided for the staff team. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

Prior to our inspection we reviewed all the information we held about the service. We had not received any statutory notifications since December 2014. The provider is required to send us notifications about important things that have happened, such as accidents, deaths and safeguarding incidents. The registered manager told us that she had sent us four death notifications during the previous twelve months and she subsequently forwarded these to us. However, we had not received them. We also looked at information we had received from other sources, such as the local authority and community professionals involved in the care and support of those who lived at the home.

Inadequate

Is the service safe?

Our findings

Everyone we spoke with said they felt safe living at Melrose. Comments we received from those who lived at the home included, "I am much better here. I feel safe"; "Staff come when I need them; no worries there"; "I don't seem to fall as much here"; "I am very safe now. It's the best move I ever made"; "I take medication, a lot in fact. I get it on time. I never have to wait for anything"; "The staff come round with my tablets regularly. I get them on time" and "I take tablets. They [the staff] leave them on the table and I take them eventually." One family member commented, "My relative has come on much better here."

At the last inspection we found that the provider had not always ensured that assessments had been conducted in order to mitigate potential risks to the health, safety and welfare of those who lived at the home.

At this inspection we looked at the care files of all 17 people who lived at Melrose and found that there were no risk assessments or plans of care in place for four of these people. One of these care files had been looked at during our previous inspection on 7 February 2017, when the individual was relatively new to the home. At that time we accepted that information was still being gathered about this person in order to generate detailed care plans and develop associated risk assessments. We looked at this person's care file again at this inspection and found that five months after admission there were still no care plans or risk assessments completed, despite them having a poor prognosis, diagnosis of diabetes, short term memory loss and poor mobility. They had also been assessed as being at high risk of falls by the funding authority. However, no risks for this person's safety and wellbeing had been considered and there were no preventative plans implemented in order to protect them from potential harm.

We discussed with the registered manager the content of the Lancashire County Council's [LCC] assessment, in relation to nutrition, which was conducted before this person was admitted to the home. This indicated that they were at risk of aspirating and required a referral to Speech and Language Therapy [SALT]. The registered manager told us that this person was not at risk of aspiration and that this information was incorrect, which was also supported by two members of staff and the individual themselves. However, the registered manager was unaware of the content of the LCC assessment and there was no evidence that the individual had been reassessed for the possibility of being at risk of aspiration. Therefore, this could have potentially had a significant impact on the person's physical health, should they have been at risk of aspiration.

We saw a care plan, which had been received from the Local Authority before one person was admitted to the home five months previously, which showed that the individual was at high risk of falling and required support with mobility and transfers. However, when we checked the care file of this person on the first day of our inspection there were no risk assessments in place in relation to falls or moving and handling. Therefore, this could have had a detrimental effect on this person's health, safety and wellbeing and could have potentially exposed them to the risk of harm.

There had not been any safeguarding training provided for staff for a period of two years and staff we spoke

with had a limited knowledge of safeguarding procedures. Safeguarding incidents had not been appropriately reported, in relation to a high number of falls. Accidents and incidents were documented. The current accident book showed that ten un-witnessed falls had occurred in the last three months, but none had been reported to the relevant authorities. One family member told us of an incident in which they were not informed of an un-witnessed fall their relative had experienced, which resulted in them sustaining a large bruise. One incident recorded this year stated that one person who lived at the home 'took the wrong medication'. It would have been more open and transparent if this read they 'were given the wrong medication.' This also should have been reported under safeguarding procedures as a medication error.

One person we pathway tracked suffered from confusion, anxiety and depression and had been referred to the Community Mental Health Team and memory clinic prior to admission four months previously. On the first day of our inspection we looked at this person's care file and found that there were no risk assessments in place in relation to this person's mental health. On the second day of our inspection we noted that some risk assessments had been undertaken for areas such as falling and moving and handling. An assessment had also been conducted for the risk of developing pressure sores, which resulted in a high risk category. However, there were no risk assessments in relation to mental health and no associated care plans had been generated. Therefore, this person remained at risk of harm.

The records of another person showed they had lost a significant amount of weight during the last year. This was initially brought to our attention by a relative of the individual. Records showed that a GP had visited, in relation to weight loss, but the person had refused any further investigation. However, this person's moving and handling risk assessment incorporated their weight, as it was in October 2015. Although this risk assessment had been reviewed each month since, the reviews stated, 'No change' or 'Remains the same'. The significant decrease in weight had not been incorporated and therefore the risk assessment was inaccurate, which could have resulted in this person being put at risk of harm.

A moving and handling risk assessment, dated 12 September 2016 had been conducted for one person, which showed them to be at high risk of falls. This had been reviewed every month until 4 July 2017 and consistently recorded, 'no change'. However, the falls risk assessment, conducted on 4 July 2017 showed that the individual was at low risk of falls. Therefore, conflicting information for the staff team had been provided, which potentially put this person at risk of receiving inappropriate or unsafe care and support, because inaccurate information had been recorded.

We found that steps had not been taken to assess people's on-going needs and plans of care or risk management plans had not been developed in order to keep them safe. This did not promote people's safety and therefore they were potentially at risk of harm.

There was no business continuity plan in place, outlining what action staff needed to take in the event of an emergency situation arising, such as gas leak, power failure, flood or utility disruption.

During the course of our inspection we assessed the management of medicines and found that this area had not improved.

At the last inspection we found that medicines were not always managed safely.

We looked at the Medication Administration Records [MARs] of seven people who lived at the home. We found that three of them did not contain photographs for identification purposes. This could have potentially resulted in medications being administered to the wrong person. All seven of these people were prescribed 'as and when required' [PRN] medicines, but four of them did not have protocols in place to

indicate when these medicines should be given and specific care plans had not been drawn up to support this. One MAR chart showed that the senior care worker had signed to indicate one person had taken their PRN medication before it had been offered. The senior carer said this was a mistake and she was sure the person would take the PRN medication. The wrong keys were sometimes recorded on the MAR charts, when medications were omitted. MAR charts we saw did not always correspond with the medication care plan. This was confusing for staff and could have resulted in the wrong medications being administered.

Five MAR charts contained gaps, with missing signatures and no reasons recorded for omissions. One person had missed their early morning medication for Parkinson's disease on the first day of our inspection, which was a significant health risk for this person and would impact on their wellbeing. It is important that this prescribed medication is not missed and is administered some time prior to the person getting up in the morning, as it helps to relax muscles and prevent rigidity of limbs.

Records showed that on one occasion the home had run out of Morphine patches for one person. The registered manager subsequently informed us that the home had not run out of the patches, but that they had been stored in another area of the home. This had not been communicated effectively to staff and therefore this person was at risk of not being administered their analgesic medication, as prescribed.

One person who lived at the home had injections every three months. However, these had not been prescribed by the GP since their admission three months earlier and at the time of our inspection were found to be overdue. There was some confusion about the administration of these injections by the District Nurses. This was because of lack of communication and organisation by the home.

Medicines were received into the home, but not checked and signed in. We counted the remaining stock of medications for four people who lived at the home. None of these coincided with the corresponding records. Hand written entries on the MAR charts had not been signed, witnessed or countersigned in order to reduce the possibility of transcription errors. MAR charts did not always correspond with the medication plans of care.

The shortfalls and serious risks to people's health and wellbeing resulted in an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to medicines management.

On the first day of our inspection we toured the premises and found that there were two bedroom doors propped open with items of furniture and a third was restricted from closing due to the carpet pile. The registered manager told us that one person refused to have their door closed. There was no automatic door closure fitted in this room, although five had recently been fitted in other areas of the home. During our tour of the premises we noted that there were several doors, which did not fit properly into the door frames. The above areas of concern would leave people at risk in the event of fire.

Infection control practices were not sufficient. There were incontinence pads in one bathroom, which were out of the packaging and open to the environment. The linoleum in one bathroom was very dirty in-between the joints. We observed a member of staff strip the bed sheet off one bed and then shake the dirty sheet out in the corridor. We noted that the hand wash dispensers by the sinks were empty. These observations could have potentially put people at risk of cross-infection and were not in accordance with the prevention and control of infection in care homes guidance.

There were some commode bowls on the floor of a shower room. These were filled with bleach and easily accessible by the people who lived at the home. There were domestic products left in the hallway

unattended and an unlocked cupboard also contained a wide range of domestic chemicals. Therefore, people were at risk of harm, should any of the products be ingested.

We noted that the light fitting was hanging down in one bedroom and one bath was worn with rough enamel. Five bed mattresses were too long for the base of the beds. If someone [staff, service users or visitors] sat on the end of the mattresses then they would most likely slip or fall onto the floor. This could expose persons to the risk of injury.

The PEEPs [Personal Emergency Evacuation Plans] we saw contained the following instructions: 'A carer to remain with each person, who is in a fire protected room in the event of fire.' Staff we spoke with were unaware of this instruction in relation to fire evacuation.

During our inspection, staff members we spoke with identified five people to us, who would be left in their rooms to await evacuation by the fire service. The above instructions could not be complied with because there were only four care workers on duty during the day, including the registered manager and at night only two staff members. Therefore, this would not be possible and would leave those who lived at the home at risk of harm. When we asked two care workers about emergency evacuation plans, they both informed us that they would attempt to get everybody out of the building. Therefore, the PEEPs had not been appropriately developed, shared and agreed by the staff team and those who lived at the home. Staff spoken with told us that there were no fire marshals allocated. One person thought it may be the registered manager, but was not sure. This left people at risk of inappropriate support should emergency evacuation be necessary.

One person had been at the home for a period of four months, but did not have a PEEP in place. The PEEP for another individual contained guidance, which did not correspond with other information within the care file in relation to their ability to mobilise. Therefore, clear guidance was not provided about how these people would be evacuated from the premises, should the need arise.

One person had an agreed DNACPR (Do not attempt Cardio Pulmonary Resuscitation) in place. This individual presented as unwell during our inspection. We looked at this person's care records and the DNACPR order was not in their file. One inspector advised the senior care worker on duty that they needed to contact the GP surgery to ensure the GP brought a copy of the DNACPR with them when they visited later that afternoon. If the inspector had not checked this, there would have been a potential risk that the person's wishes would not have been followed in the event of cardiac arrest.

The above observations which placed people at risk of harm constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel records of three staff members who were employed at Melrose. We found that recruitment practices adopted by the home were not robust. There was no evidence available to show that full Disclosure and Barring Service [DBS] checks had been conducted for two of the staff members whose personnel files we looked at. DBS snapshots for these two staff members were also dated after the contract start dates. DBS checks allow managers to establish if any prospective employees have a criminal record or if they have received any cautions, to enable employers to make a decision about appointing them.

One staff member had completed a brief application form only and the two references obtained did not provide positive feedback. Risk assessments had not been conducted for this member of staff in relation to information recorded on the written references. The provider had not explored this further by taking steps to ensure this person was suitable for the role of supporting vulnerable people.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Records showed that systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to ensure they were fit for use. Some internal checks had also been completed, such as fire extinguishers, fire alarm system, fire exit doors and automatic door releases.

We observed staff members transferring people and helping them to mobilise on several occasions. These manoeuvres were always conducted in a safe and competent manner, whilst good explanations were provided to the individual being assisted, with reassurance, encouragement and praise being offered throughout.

Staff members we spoke with told us they were happy with the current staffing levels and felt that the care provided for those who lived at the home was consistent, as little agency staff were used. However, we were told that more staff would be beneficial during holiday periods and absences, such as sickness. The duty rotas we saw confirmed the numbers of staff on duty and these seemed to be sufficient to meet the needs of those who lived at the home.

We were told that there was a verbal handover at the beginning of each shift, which was entered in to the communication book. This helped the staff team to keep up to date with any changes and allowed important information to be passed on. Staff we spoke with felt that it would be beneficial if designated staff were appointed for the laundry and also to do the cleaning at weekend, so that care staff could spend more time with those who lived at the home.

Inadequate

Is the service effective?

Our findings

One person we spoke with commented, "I wouldn't want to be anywhere else. It is marvellous. My bedroom is lovely."

All the people we spoke with who lived at the home said they felt confident that the staff had the skills needed to support them. They were also complimentary about the food served. One person told us, "I have put on a stone in three months. The food is ever so good. It is so relaxed here."

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principals of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection we found that the provider had not ensured that consent to care and treatment had always been sought from people who were assessed as having the capacity to make decisions.

During the first day of our inspection we looked at the care files of all 17 people who lived at the home to ascertain if formal consent had been gained, in order to deliver the care and support people needed. There was no consent, of any kind obtained from four people who lived at the home and who had not been assessed as lacking capacity to make decisions. The consent forms for others had only been partially completed. For example, most people had a signed consent in relation to how often they wished to be checked during the night. This was considered to be good practice. However, most of these records failed to indicate the option individuals had selected and so they were ineffective. Therefore, people were receiving care and support, which they had not formally consented to.

We again looked at the care files for the above four people two weeks later and found that no further steps had been taken to address the failure in obtaining consent to care and treatment.

The above observations constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the principles and guidelines of the Mental Capacity Act 2005 and associated Code of Practice, in relation to four people who lived at the home had not been implemented. This was because their mental capacity had not been assessed, in order to determine if they were able to make particular

decisions about the care and treatment they received. However, an application to deprive one of these people of their liberty had been made to the Local Authority prior to a mental capacity assessment having been conducted. There was no information available to demonstrate that best interest decisions had been made to support these people, who may have lacked capacity to give consent to their own care and treatment.

The mental capacity assessments, which had been conducted were very generic and did not identify specific decisions. A mental capacity assessment for one person had been partially completed, which indicated that there was an impairment of, or disturbance in the functioning of the person's mind or brain. The GP's notes showed that this person had vascular dementia, anxiety and was low in spirits. It was established that this individual was under constant supervision and would have been restricted from leaving the property alone, if they expressed a wish to do so. This was therefore depriving them of their liberty. However, a DoLS application had not been made to the local authority.

The Registered Manager told us there were only two people who lived at Melrose who lacked the capacity to make decisions and that Deprivation of Liberty Safeguard [DoLS] applications had been made on their behalf. From looking at care files it was evident that a number of people had mental health issues. However, mental capacity and DoLS assessments had not been conducted to establish if they were able to give consent and if DoLS applications were needed, in order to protect them from abuse. Therefore, appropriate steps had not been taken to ensure that people who lived at the home were not being unlawfully restricted or controlled.

The above observations constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we looked at the personnel records of three staff members, who had worked at Melrose for varying lengths of time. Two of the three files we saw did not contain any formal induction records. The third showed that an induction programme had been completed on commencement of employment. However, this was a simple 'tick list', although it did include one shadow shift.

We asked to see the staff training matrix, but there was none available and certificates of training held on the three staff personnel files we saw were sparse. No training had been provided for these staff members so far this year. A minimal amount of online training had been provided during the previous year. For example, training around fire awareness, food hygiene and moving and handling had been provided for some staff during 2016. Some staff we spoke with told us that they preferred practical hands on training, rather than online learning. Our findings showed that training for the staff team was inadequate, as modules were not taking place to allow staff members to gain confidence and expertise in delivering the care and support which people needed. At the time of our inspection the registered manager told us that she had booked 12 staff members on moving and handling and medication training. There were no records available to show that staff had completed training during the last two years in relation to safeguarding, the Mental Capacity Act, Deprivation of Liberty Safeguards and dementia awareness. Staff we spoke with had limited knowledge of safeguarding procedures and the principles of the Mental Capacity Act.

There were no records in the personnel files we saw to show that staff members were supported through regular supervision sessions. Appraisals were on all three staff files, but these were over twelve months old. Our findings showed that staff were not supported to receive sufficient support or supervision as was necessary to enable them to carry out the duties they were employed to perform.

The above observations constituted a breach of Regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

During the course of our inspection we toured the premises and found that although the building was warm and homely, it was in need of updating and modernising throughout. The home was dated and tired looking. There was no evidence available of ongoing upgrading to the environment. Careful consideration needs to be given to the type of carpets, as heavily pattered ones are not suitable for those who live with dementia and they increase the risk of falls. It is recommended that attention is given to the environment, in order to improve the surroundings for those who live at the home.

People's dietary preferences were sometimes recorded in care files. For example, the records of one person showed they did not like garlic or spicy foods, but preferred traditional home cooking. We saw people being offered a variety of choices throughout the day and we observed the meal service at lunch time. The dining tables were set well with tea and coffee being available for people to help themselves. However, assistance was provided, if needed. The menu was designed to cover a four week rotational period, so that a variety of meal choices was available. Two people confirmed that there was a choice of meals and that staff asked them in the morning what they would like to eat for their meals on that day. However, one person commented, "We got a drink at 10.30 this morning. That's unusual we never get one then. It's because you are here." We also noted that drinks were served at 3pm. People told us this was unusual too.

Where needed staff were observed supporting people to eat in a dignified and caring manner. However, independence was also encouraged, as appropriate. People's weights were being monitored regularly, so that any changes could be identified and steps taken to address any concerns about weight fluctuation.

Requires Improvement

Is the service caring?

Our findings

One person we spoke with told us, "The care is good. We choose when we get up and when we go to bed or when we want a bath. Staff are good like that; they always [verbally] ask first." We saw that staff members asked people if they were alright throughout the day. Another person commented, "I've asked for my laundry twice today, but they say, 'Here she is mithering again'. It puts you off saying anything."

There were 17 people who lived at Melrose at the time of our inspection. We spoke with nine of them and two family members, who provided us with positive feedback about the caring attitude of the staff team. However, those who lived at the home did not know what a care plan was. However, one relative told us that they did recall seeing a plan of care.

We observed medications being administered without any consideration for dignity. The senior care worker giving out the medicines did so in a loud and undignified manner. Inspectors observed them say to one person, "[Name] your pills." "Have you swallowed it?" The senior care worker then asked if this person wanted 'as and when required' [PRN] medicines. They said that they did, but when the senior care worker returned with the PRN medication they had changed their mind and did not want them. The senior carer responded by saying, "I can't pot them now", so the person took the tablets offered, against their wishes. This did not promote dignity, choice or respect.

We established that one person who lived at the home was responsible for their own medicines. This was discussed with a senior care worker who told us, "The first time [name] makes a mistake, they [the medicines] will be taken off [name]." This did not promote choice and respect for this individual.

The Personal Emergency Evacuation Plan [PEEP] of one person who had lived at Melrose for three months showed they had a Learning Disability. We looked at this individual's care records and found that this diagnosis had never been made by a health care professional. We discussed this person's needs with a senior care worker and the registered manager of the home. It was evident the staff had surmised they had a Learning Disability because they were withdrawn, lacked social skills, did not mix well with others and had difficulty in absorbing information. We explored this further. The registered manager eventually told us that this person did not have a Learning Disability and stated, "It's just a label they have". This was undignified and did not promote respect for this individual.

On the first day of our inspection we noted one person to be poorly in bed following surgery at hospital the previous day. There was a full urine bottle on their bedside cabinet and their T-shirt had dried blood stains on it. We noted another person to have very dirty finger nails. This did not promote dignity and respect of the individuals concerned.

The bathing record for one person whose care and support we pathway tracked stated, 'Strip washed daily.' We found this entry to be undignified and disrespectful towards the individual. These records showed this person had an assisted bath infrequently. For example, the dates an assisted bath was given were recorded on 1st February 2017, 18th March 2017, 18th and 27th May 2017 and 14th June 2017.

The above findings constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we observed staff interacting with people in a pleasant and kind manner. However, observations made by staff were more regular in one of the lounges than the other. Whilst we were at the home an ex-resident visited to see the staff and current residents in the home. This person commented, "I do miss you all. I want to come back."

We saw that people appeared relaxed in their surroundings and comfortable in the presence of staff members. Staff were seen to approach people in a kind way and they also helped people to remain as independent as possible.

Inadequate

Is the service responsive?

Our findings

One person we spoke with told us, "If there are any activities on, they never come down this end. I have asked not to sit in this draft near the door. Look I have a blanket and cushion at the side of me to stop the draft."

Other comments we received from people included, "I go out sometimes. Do a bit of shopping"; "I've not been out for some time now"; "They [the staff] said about activities on a Tuesday and Thursday, but it hasn't come off" and "I used to go out locally with my walking stick. I don't anymore. I miss that."

One family member told us that due to their relative not understanding anymore, the home speaks directly to them about decisions, such as Do Not Attempt Cardio-Pulmonary Resuscitation [DNACPR]. This person commented, "My relative has lost a lot of weight recently, as they are not eating and they are refusing treatment, but staff keep me informed."

At the last inspection we found the provider had not ensured that the care planning process always accurately reflected people's needs and was always person centred.

We looked at the care files of all 17 people who lived at Melrose and pathway tracked the care of seven of them. Pathway tracking is a system we use to ensure people are receiving the care and support they need.

We found that needs assessments had been conducted before people were admitted to the home. However, these provided basic information only. Some records outlined people's preferences and what they liked to do, including their past hobbies and interests. Although some care files we saw contained a good description of people's needs and how these were to be best met, we found on occasions contradictory information was provided for the staff team. For example, the moving and handling risk assessment for one person showed that they were at high risk of falling. However, the falls risk assessment indicated that they were at low risk of falling. The care plan from the local authority for another person identified an allergy to a specific medication, but the home's records stated, 'No known allergies.' This did not demonstrate that person centred care was consistent.

We also found that four people, who had lived at Melrose for several months did not have any care plans in place and no risk assessments had been conducted. Each of these individuals had significant health and social care needs and required various levels of help, as identified from our observations and from information obtained before they came to live at the home. Therefore, guidance for the staff team about the needs of these people and how they were to be best met was not provided. This put people at risk of receiving unsafe or inappropriate care and support due to the failings in planning people's care properly and in accordance with their needs. The registered manager was aware that four people who had lived at the home for some time did not have care plans or risk assessments in place. This was a serious concern.

We established that one person had returned to the home following a surgical procedure the day prior to the commencement of our inspection. This person was clearly requiring medical attention, which was not

being sufficiently sought. This individual did not have a short term care plan or risk assessment in place in relation to the surgical procedure and medical support needed. This person was eventually readmitted to hospital for further treatment.

The provider had not ensured that steps had been taken to assess people's on-going needs and had not developed any plans of care or risk management plans to keep them safe.

Taking the above observations into account we found that there were serious risks to service users' life, health and wellbeing. This was because medical attention had not been sought, as was needed and because the care planning process was not person centred and did not always accurately reflect people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had informed us that activities were provided every Tuesday and Thursday. However, the first day of our inspection was conducted on a Tuesday and we did not observe any activities taking place. We later established that the activity coordinator had taken one person into Preston shopping and for a walk. We saw them return to the home during the afternoon. Therefore, the people who remained at the home did not have the opportunity to enjoy any activities on that particular day. We saw another person arrange to go to the bank in a taxi, which supported independence and choice. One person was enjoying the challenge of doing a crossword in the newspaper and another was assisted to go to the local shop to buy a puzzle book.

At 2pm there were ten people sitting in one of the lounges. Seven of them were asleep, one was reading a newspaper and two were having a conversation. A visitor arrived who spoke with those who were awake. During a half hour observation there was little interaction attempted by the care workers with those who lived at the home. Some people we spoke with were satisfied with the amount of activities provided. We were told, "A lady comes to do activities with us. She throws a ball to us. We play bingo and sit in the garden during the better weather. It is lovely. There is a nice tree to sit under if it is hot. We have a sing song and play dominoes sometimes." Staff spoken with felt that more hours could be allocated for activities, so that people could be better occupied.

We recommend that the provision of activities be reviewed and tailored to meet the needs, preferences and wishes of those who live at the home.

A complaints policy was in place at the home, which included specific time frames to expect during an investigation and included external agencies that may be contacted, if it was necessary. This was displayed in the reception area of the home. A system was in place for recording any complaints received. The last recorded complaint was in 2009. When we asked people about making a complaint, the responses included, "I'm not sure about complaining. I don't want any atmosphere"; "I would say if something is wrong"; "I haven't got any complaints if I did I would say" and "I have told staff about things, but they're not bothered." One family member told us, "I know my relative wouldn't say anything. She wouldn't want to bother anyone." One person did not feel that it was worthwhile to raise their concerns again, because no action had been taken when their concern was initially raised. This indicated that residents sometimes did not feel comfortable enough to make complaints to the home.

Inadequate

Is the service well-led?

Our findings

The registered manager was on duty at the time of our inspection. She had managed the day-to-day operation of the home for eight years, but had worked at Melrose for a period of 20 years.

At the last inspection we found that the provider had not ensured that effective systems had been established in order to assess and monitor the quality of service provided.

During the course of this inspection we assessed the systems for monitoring the quality of service provided. We found the quality monitoring, governance and oversight systems continued to be deficient. Although some quality surveys had been completed by those who lived at the home and their relatives since our last inspection, we found there were still no adequate audits in place. The registered manager told us that she had designed her own monthly management audit tool, but this was a simple list of 28 audits, which she considered needing to be done, but there was no system in place for recording what had been checked within each audit and none had been completed, except for a recent medication audit.

The last two medication audits were provided to us. The first was over a year old and the second had been conducted in June 2017. However, there was no evidence to show that an audit trail of medicines management had been frequently or adequately completed, as the audits contained insufficient information and did not recognise the shortfalls in medicine management, which we identified during our inspection. This exposed service users to the risk of harm and indicated that systems and processes were not established or operating effectively to ensure compliance with the regulations. There was a failure to assess, monitor and improve the quality and safety of the service provided or to monitor and mitigate the risks relating to the health and safety and welfare of service uses at Melrose Residential Home.

On the first day of our inspection one inspector looked at the fire records, which stated the fire alarm system was to be tested weekly. The last test of the fire alarm system was shown to be on 6 June 2017, three weeks prior to our inspection. On the second day of our inspection another inspector checked the fire records again, which showed that the fire alarm system had been tested each week. The fire alarm tests for 13 and 20 June 2017 had been added and signed by the registered manager between 27 June and 30 June. We spoke with the registered manager about this, who confirmed that she had backdated these records.

On the second day of our inspection we noted that risk assessments in relation to moving and handling, falls and pressure damage had been completed for one person since the first day of our inspection. These showed that risk assessment reviews had been conducted and signed by the registered manager every month since this person's admission to the home in February 2017. These were not in place on the first inspection date and had been completed by the registered manager since then. We discussed this with the registered manager, who confirmed that she had backdated these records.

We advised the registered manager on 30 June 2017 that the practice of backdating records was not acceptable.

In terms of the fitness requirements for registered managers, the backdating of records demonstrates a lack of skill and raises concerns in relation to the registered manager having the necessary good character, in accordance with the regulations.

On the second day of our inspection the registered manager told us that she had allocated carers to complete the blank care plans and risk assessments following the first day of our inspection six days earlier. However, this had not been done. It is the registered manager's responsibility to ensure that clear guidance is provided for the staff team, in relation to people's needs and how these are to be best met, in order to protect them from harm. Staff we spoke with felt morale was low. We were told that improvements could be made in communication and support from the management of the home.

Care staff we spoke with said they had been allocated one or two care plans to complete. They all told us that they had not received training in this area and some told us that they were 'scared' about taking on this responsibility. We discussed this with the registered manager of the home, who was aware that care staff were nervous about writing care plans, but evidently did not feel that training was necessary for the care workers in this area.

There was no quality monitoring systems in place for care planning. On the second day of our inspection the registered manager told us that she had looked through the care files, to see what needed doing, but had not formally recorded her findings.

The registered manager had been instructed on four separate occasions from February 2017 to June 2017 to ensure that care plans and risk assessments were in place for all those who lived at the home. On 10 July 2017 we conducted the final day of this inspection and found that there had been little or no improvement made.

Due to the number of continued and new breaches identified at the time of this inspection, we found there had been a disregard for legal requirements, in terms of demonstrating compliance with the regulations and meeting the requirements, as set at the previous inspections of Melrose Residential Home. This is evidence of a history of failing to respond adequately to serious concerns raised by CQC.

A person shall not manage the carrying on of a regulated activity as a registered manager unless they are fit to do so. A manager is not fit to be a registered manager in respect of a regulated activity unless they have the necessary skills to manage the carrying on of the regulated activity.

At this inspection we were aware that the registered manager was failing to demonstrate she had the necessary skills to manage Melrose Residential Home. This was demonstrated by the fact that multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified, some of which were continuous failings under her management.

This was a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirements relating to registered managers.

We had not received any statutory notifications from the home since October 2014. We were told that four people had passed away during the previous twelve months. The registered manager told us that these death notifications had been forwarded to CQC, as required. We subsequently asked for this confirmation to be forwarded. The statutory death notifications were then sent to us. However, we had not received these at the time the deaths had occurred.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 Notification of Deaths.

Accident records showed that from April 2017 to June 2017 there had been ten unwitnessed falls, but none of these had been reported under safeguarding procedures. The provider had not taken the appropriate steps to share specific incidents with the relevant statutory bodies, in accordance with the Care Quality Commission (Registration) Regulations 2009. It can be a criminal offence for failure to make statutory notifications, without undue delay.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

On the first day of our inspection the Registered Manager told us that they were expecting the provider to visit during the day. At the end of this inspection day at 5pm we asked if the provider was still expected. We were told that he had been to the home and had since left. The person referred to as the provider had not made himself known to us. It is of concern to the Commission that the registered manager referred to this person as the provider, as he is not one of the company partnership members and he is not registered with the Care Quality Commission [CQC] as a registered provider.

At our inspection in February 2017 we reported that the registered manager could not manage the service, whilst working on the floor as a carer for the majority of their working hours. The registered provider accepted this, as written in their action plan. Therefore, the provider made the registered manager supernumerary, to allow time to accommodate managerial and administrative duties. However, although this arrangement had been in place for six weeks prior to our inspection little progress had been made in that time. We discussed this with the registered manager, who informed us that they had to cover sickness or absences, when these occurred. The duty rotas showed that the Registered Manager had covered ten shifts during the previous six week period.

There had been no management meetings between the provider and registered manager since our last inspection. No staff meetings had been held and no meetings for residents and relatives had been arranged. Therefore, effective processes for assessing and monitoring the quality of service provided and for obtaining people's views were not in place. None of the residents we spoke with could recall attending a residents and relatives meeting and there was no evidence available to show that these had been held. However, people we spoke with confirmed that the registered manager of the home was accessible to discuss any concerns they may have, so that issues could be dealt with promptly.

A wide range of policies and procedures were available at the home. These covered areas, such as infection control, fire safety, complaints, dignity, equal opportunities, medication, safeguarding vulnerable adults, whistle-blowing, confidentiality, health and safety and the Mental Capacity Act and Deprivation of Liberty Safeguards. However, due to the high number of regulations breached at this inspection it was clear that these were not being followed in day to day practice.
The registered manager told us that the provider visited the home twice a week, but there was no evidence available to demonstrate how the service was being monitored during these visits. Systems had not been established to effectively assess and monitor the quality of service provided. There were no audits of care planning or of accidents and incidents, so that any areas for improvement could be identified and rectified within an acceptable timeframe.

The above findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance

We did see a range of thank you notes from people who had resided at the home and their families, which all contained positive comments.

There was a Statement of Purpose in place at the home, which provided people with current information about Melrose, the facilities available and the services offered. The previous rating awarded by the Care Quality Commission was displayed within the home.

Some care files we saw recorded involvement with community professionals, such as GPs, district nurses, chiropodists and mental health teams. However, there was no evidence available to show that one person had received dental input, although they had their own teeth.

Not all staff members we spoke with told us that they felt well supported by the management of the home, but said they were happy working at Melrose. One member of staff said, "I love working at Melrose."