Quality Outcomes Report 2015

MELROSE HOUSE
October 2015

Name of Service:	Melrose House
Date of Visit:	22nd and 23rd October 2015
Manager:	Shirley Ward
Person in Charge on day of visit:	Shirley Ward
Contracts Team Officers:	Wendy Gray and Audrey Keville

Not Met	Poor evidence of outcome being met
Partially Met	Good evidence of outcome being met /majority of evidence is in place but not all
Fully Met	All evidence is in place demonstrating the outcome is fully met

SUMMARY;

Melrose House is a large, comfortable, terraced property which is home to nine service users with mental health issues or a learning disability. It is situated on the sea front in the Cullercoats area of North Tyneside, and is close to local shops and travel links. The home has been considerably improved in the last year, with the whole house being redecorated to a very high standard, at a considerable cost to the Owner. Feedback from the staff team and from the service users during the visit was very positive, with morale appearing high. It is recommended that all policies and procedures are updated, as this process appears to have lapsed, and information in some of the policies are out of date and unhelpful. This is especially pertinent in the case of updating the Business Continuity Plan which will guide staff in an emergency. Urgent attention should be given to Health and Safety and Safeguarding issues outlined in the report.

Main Outcome	Related Outcome Measures	Comments	Outcome	Outcome Score
ople benefit from Personalised Care	1.1 Effective assessment procedures ensure that placements are appropriate and well planned	This outcome was partially met. There had been pre-assessment documents filled in with service users in April 2015 but the people had been resident in Melrose House for up to 13 years before this was filled in. It is recommended that any new placement has a pre-assessment carried out to determine whether the home can accommodate the person's needs. In practice, the Manager does ensure that any new resident can be successfully accommodated but this needs to be better evidenced and formally documented, with the individual signing to confirm consent to the placement. This is especially important as there is the potential for the service to be asked to accommodate extremely complex people, with consideration being made as to the impact on the existing service users. It would be good practice for the Emergency Admissions Policy to make reference to completing a pre-assessment.	Partially met	1
	1.2 Effective care planning and review processes ensure people receive excellent, individualised care	This outcome was partially met. It was not evident in all the files viewed that a person centred planning tool such as the Recovery Star had been completed. There was good evidence in one file that a WRAP plan had been completed which looked at personalised ways to maintain the service user's mental good health. It is recommended that care files include a record of the person's life history and information on any cultural or religious beliefs. There was a basic process in place to review the care plans, although this could be expanded to include information about who exactly had been involved in the process. There was a process in place to audit the care plans, but this was completed with just a tick or a date. It is recommended that the person auditing the file signs and dates when complete, as this will give confirmation of who has carried out this procedure and when. The care plans viewed did not include any information about individuals' long term goals or ambitions. It is recommended that this information is added to the care plans, to confirm what the person is wanting to achieve.	Partially met	1

Main Outcome	Related Outcome Measures	Comments	Outcome	Outcome Score
1. Pe	1.3 Positive risk taking ensures people are encouraged to maintain independence	This outcome was not met. There was a policy which referred to positive risk taking briefly, but this was not dated and it was not clear if this had been reviewed in the last year. It is recommended that positive risk is more proactively discussed in reviews. It was evident that positive risks were being taken and managed, but this needs to be backed up with documentation and recording. Several of the service users access the community independently. There was no evidence of risk assessments in place. It is recommended that the care files include documentation to confirm that the individual has the capacity and ability to do this independently, and that risk assessments are in place to confirm that consideration has been given and risks are minimised. Most residents go out unaccompanied to at least some places and it would be good to evidence steps in place such as advice given to carry phones or mention expected time of return. One service user accesses the kitchen in the middle of the night to make hot drinks. It would be good practice to record that the risks behind this have been considered and minimised.	Not met	0
			Score	**2**
2. People are supported by excellent staff	2.1 Comprehensive training procedures ensure staff have access to up to date knowledge and skills that is appropriate to the needs of the clients receiving the service.	This outcome was partially met. Only two of the five members of staff had completed the full in-house induction. The Manager commented that two of the staff have just joined the company and will be progressing with this imminently, as well as starting the new Care Certificate training. It is recommended that the induction includes discussion around the safeguarding of vulnerable adults. Mandatory first aid training had lapsed, with only one of the five members of staff having attended a course in the last three years. Four of the five staff had completed Medication Awareness level 2 training in the last three years. The other member of staff was new to the team and we were advised that she is not responsible for administering medication, as she currently does not lone work or do sleep ins. This was confirmed by viewing the rota. We were informed by the Manager that North Tyneside Council's Safeguarding training was booked for staff to attend in November, December and January as three members of staff's training had lapsed. However, NTC training department confirmed that there is no record of anyone from the organisation being booked onto this training. Four out of the five staff had completed moving and handling training in the last year. It is positive that there is not a reliance for staff to complete e-learning and that staff are given the opportunity to complete courses face to face. There was a range of additional courses available which were very appropriate given the service user group. It is recommended that the training matrix be expanded so that an expiry date is clearly visible for each person's training course. The Manager was aware of the National Safeguarding Competence Framework but the forms had not been completed. Advice was given that she was going to complete this in the next few months. It is advised that all staff should have their competencies assessed as a matter of priority.	Partially met	1
	2.2 Staff are supported to undertake their duties	This outcome was partially met. It was good to see that supervisions were held regularly, but minutes showed a basic record of discussions held, and the quality of the information recorded was varied. The staff meetings were very well attended, but the agenda was very repetitive, with minutes reminding staff about what they should be doing in regards to good practice. It is recommended that staff sign the minutes to show they attended or as an acknowledgement that they have read the minutes. Handovers are in place, but it would be good practice for staff to sign to confirm receipt of the information.	Partially met	1
	2.3 Positive Staff Morale ensures people receive dignified care from a stable and productive staff team	This outcome was met overall. There is a format in place for a staff satisfaction survey, but there was only one form completed, so there was no collation of evidence or an action plan. It was lovely to hear the very positive feedback from the service users about the staff and the service that they receive. It was clear from talking to staff that morale is very good, they seemed very motivated and spoke fondly of the service users. Staff also were very complimentary about the provider.	Fully met	2
			Score	**4**

Main Outcome	Related Outcome Measures	Comments	Outcome	Outcome Score
3. Management systems ensure an excellent quality of service provision	3.1 Effective quality assurance procedures ensure the manager has a clear overview of service performance	This outcome was partially met. The care files and care plans are audited, and a tick or a date entered. It is recommended that the audit shows the date of checking along with the signature of the person completing the task. There was clear instructions as regards to auditing accidents and incidents. There had been no events recorded in the last year. The Manager said that there had been no incidents or near misses. It would be good practice to record that the monthly check had been carried out, and that there were no incidents if this was the case. There was evidence of stakeholder surveys being carried out in the past but it was unclear what the involvement the contributors had whether family members or visiting professionals. The results were not collated. The policies viewed had the names of irrelevant companies on them, so it is recommended that policies are reviewed and updated with the correct up-to-date information on them. It was good to see that the Manager sends the Owner a report every week updating him on all aspects of the service, including updates about service users, staffing, the building and supplies (e.g. PPE which the Owner orders).	Partially met	1
	3.2 Effective Business Continuity procedures ensure the service can continue to care for people during crisis situations	This outcome was not met. It is recommended that the whole document is reviewed and updated on a yearly basis, as the information in the document gave advice for the service users to be relocated to Melrose House's "sister home" which is the main contact (this was advice from previous times when the home named was linked to Melrose House. It now has no links to Melrose House so an alternative address should be given with contact numbers listed). The advice given in the Business Continuity Plan was very generic, and it was felt that it did not give specific advice for staff to follow in an emergency e.g. advice was to; "consider hiring a mobile kitchen" or "consider establishing a team of procurers who contact local suppliers". It is recommended that the advice for loss of key staff is included, and gives advice on what to do e.g. to contact Manager, staff team, agencies etc. The advice given in the event of loss of IT and communication facilities should be expanded to give specific details about who to contact e.g. internet supplier, telephone provider and any further advice. Similarly, the information regarding loss of water supply should give definite advice. Throughout the Business Continuity Plan telephone numbers should be included to indicate how to contact people or services. Staff should sign to confirm they are aware of the plan, and trained in how to respond. Currently the Business Continuity Plan is in pencil, it is recommended that either pen-written or typed advice would be more appropriate.	Not met	0
	3.3Effective recruitment procedures ensure the right staff are employed and people are protected from harm	This outcome was partially met. We looked at two staff files during the visit. One staff file that we looked at showed only one reference, which was from several years ago. Another file showed two references had been sought, but one previous employer gave very little information that could be used to inform the Manager of the suitability of the person. It is recommended that one reference should be the staff member's current or most recent employer. It was not evident that this was the case in the references viewed. None of the references were signed by the Manager to confirm they had been verified. It is recommended that the Manager verifies the references and signs to confirm this has taken place. Both files had DBS checks completed, one was an unclear DBS with a police caution 6 years ago. The Manager addressed this at the time of employment and it was considered a historical event. There is a Rehabilitation of Offenders policy which states that no conviction is regarded as spent, but did not include advice on cautions and reprimands. It is advised that this be included when the policy is updated.	Partially met	1
	3.4 Effective staff management ensures the right numbers of staff are available at the right time and have the right skills, knowledge, experience and competencies to carry out these duties.	This outcome was fully met.	Fully met	2

Main Outcome	Related Outcome Measures	Comments	Outcome	Outcome Score
	3.5 Robust financial procedures ensure people retain as much financial independence as possible and are protected from financial abuse	This outcome was met overall. Monies are checked on a daily basis and signed by the member of staff on duty, The Manager checks and signs this off weekly. It is then sent to the Owner every Friday as part of the quality assurance process. It was explained that some service users do not wish to sign for their money when taking it out of the office. Advice was given for a statement to be added to the top of their finance balance sheet to confirm that the service user has capacity and has chosen to opt out of signing each transaction, and get the service user to sign this statement. It is recommended that the policy for Handling of Residents Monies be updated as this was written in 2009, and refers to another care home rather than Melrose House.	Fully met	2
			Score	**6**
sparent, consistent and equitable service through effective policies and procedures	4.1 Effective Health and Safety procedures ensure people are cared for in a safe environment	This outcome was not met. There was a draft Health and Safety Policy held in the Policies and Procedures file which was dated 2001. This document gave instructions on how to write a policy and was not specific to Melrose House. There was a separate Health and Safety Policy that was drawn up by Citation in 2013. It is recommended that this is updated yearly, especially as it was signed by the previous Manager. The Health and Safety Policy made reference to a named Health and Safety representative. There was no evidence as to who this is. Verbal advice from the Manager was that the Owner and herself would be the appropriate people to undertake this role. It is recommended that the Health and Safety Policy is expanded to include what resources are available, and who is responsible for the policy and that it is regularly reviewed and developed as needed. It would be good practice to include Health and Safety as a standard agenda item within team meetings. It was good to see that any building issues are discussed in supervisions. It was verbally passed over that informal discussions were being held as regards to Health and Safety matters. It would be good to record these discussions, along with dates and actions taken. The procedure for reporting incidents included reference to reporting accidents, but there was no evidence of a log being in place. The Manager advised that there had not been any accidents or incidents in the last year. Monthly audits and building inspections were carried out monthly by the Manager, but there were no action plans moving forward. The Fire Policy viewed was a generic policy dated 2013-14 which appeared to be more suited to Home Care services. The Manager had carried out a Fire Risk Assessment but it was unclear when this was dated, and whether the Manager is suitably qualified to carry out this task. The Manager confirmed that the Fire Authority had carried out a visit earlier this year, to check her Fire Risk Assessment. She shared that they had not supplied any written advice or information following the visit, and that there were no actions needing to be followed up. It was good to see that fire evacuation procedures were being rehearsed. It is recommended that the procedure for the night time procedure be expanded to give clear clarification as to what the lone working sleepover staff responsibilities are e.g. raise the alarm, assist service users. The PEEPs viewed were either not dated or signed, or they were last updated in August 2012. It is recommended that these are updated for all service users, and that they are expanded to include what actions to take in the event of both day time and night time evacuations. It is also recommended that practice drills are carried out at night time when only one staff member is present. Talking to service users during the visit, they demonstrated they were clear of what to do in the event of a fire.	Not met	0
	4.2 Equal Opportunities procedures promote equal access to services and protect people from discrimination	This outcome was not met. The Equality and Diversity Policy viewed was in the form of an advice sheet of what to include in a policy. This was dated 2012. It is recommended that a policy specific to Melrose House be produced. Recruitment procedures should be expanded to include information around how consideration has been given to gender of candidates when making the interview panels up. There was no evidence that Equality Impact Assessments were carried out when reviewing policies and procedures. The home currently only employs female staff. It would be good practice to record on service users' files that they have been consulted as to whether they have been given a choice or have a preference as to the gender of the member of staff providing their personal care.	Not met	0

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4. People benefit from a tran	4.3 Proactive Complaints and Compliments procedures ensure services are reactive and responsive to people's needs	This outcome was met overall. There was a good complaints policy which was also available in an easy read version. It is recommended that staff, service users and families are encouraged to raise concerns via team meetings, 1-1 supervision sessions, service user meetings or families meetings. It was good to see that no complaints had been received in the last year, and there was a clear procedure and form in place to log them when received. The service users we spoke to during the visit were confident of how to complain.	Fully met	2
	4.4 Confidentiality and data protection procedures ensure that sensitive information is treated with respect	This outcome was partially met. The confidentiality policy was out of date and made reference to Sovereign Care, not Melrose House Ltd. The service is registered under the Data Protection Act (no. Z365865X, expires 28th April 2016). The policies covering the use of mobile phones, photographic equipment and social networking sites were a general NHS Trust policy from 2008, which did not specifically reference Melrose House. The safe storage facility in the office was extremely well organised and effective. It is recommended that the confidentiality policy be expanded to make reference that an individual's financial status is confidential. There was a very good care plan in one service user's file which documented the importance of confidentiality, as the service user had been disclosing information about other service users outside of Melrose House. This was signed by the service user and staff. It was good to see that the service had taken this breach of confidentiality seriously.	Partially met	1
			Score	**3**
perience dignity and respect	5.1 People are able to engage in meaningful activity and occupation	This outcome was met overall. A number of service users are independent and have many skills both in the home and also when travelling or socialising in the community. There was good evidence that people were encouraged to participate in the day to day jobs around the home. Service users have 1-1 sessions with their key workers, but these tended to cover health issues such as hospital visits and moods. It is recommended that these sessions include discussions about future wishes for activities and participating in them. It was acknowledged that some of the service users were difficult to motivate, depending on their mental health presentation or in one case their physical health. It would be worthwhile exploring activities for this person which can be carried out in the home, and record if she engages in the event. The service has actively tried to motivate people by finding events which they have a particular interest in e.g. steam train experiences or stargazing. It was excellent to see that the service has supported a service user to apply for employment at a local supermarket.	Fully met	2
	5.2 People are encouraged and supported to maintain and develop relationships	This outcome was fully met.	Fully met	2
	5.3 People are proactively involved in services	This outcome was partially met. Service users form part of the recruitment panel, and prospective employees are invited to spend time with the service users, where observations can be made about how they relate and interact with the service users. It is recommended that this interaction is recorded formally. It was good to see that service user meetings are held regularly. Minutes showed that a lot of the discussion was around reminding people of the house rules. It would be good if these meetings could be used to explore people's views and preferences around a range of topics e.g. food menus, future activities etc. It is acknowledged that the service users do not have close family members who could be involved in recruitment or meetings. It was good to see that a service user survey had been carried out, with the results being mainly positive. It is recommended that the results be collated and an action plan be devised, moving forward.	Partially met	1

Main Outcome	Related Outcome Measures	Comments	Outcome	Outcome Score
5. People ex	5.4 People experience Choice and Control in every part of their life	This outcome was partially met. Documentation was viewed which stated that service users had to be in their rooms by 11pm, and that they could not access the kitchen during the night. We spoke to one resident who said that she often got up in the night and went to the kitchen to make a cup of tea. In discussion with the Manager, she said that these stipulations were not as strict as dictated, and people could access the kitchen. It is recommended that appropriate risk assessments are put in place for those who wish to access the kitchen during the night.	Partially met	1
	5.5 Privacy is a valued part of everyday life	This outcome was met overall. It is recommended that policies covering the service users' rights to who has access to their home is updated.	Fully met	2
	5.6 People experience a sense of belonging and being a valued part of the community	This outcome was fully met. The majority of service users are independent and access their chosen activity in the community without support from staff. It was pleasing to see that one service user has been supported and encouraged to volunteer at a placement within the community.	Fully met	2
	5.7 People have timely and appropriate access to information	This outcome was met overall. The service user guide was out of date and details of the Manager and CQC inspector needed updating. It is recommended that the service user guide includes reference to safeguarding procedures. It was felt that service user meetings could be used to share information with people about how they can access information that is relevant to them, and this be recorded formally. It was good to see that service users sign their files to confirm they are aware they can access them.	Fully met	2
			Score	12
:cted from avoidable harm and are cared for in a safe environment	6.1 The Mental Capacity Act 2005 and Deprivation of Liberty procedures are effective and ensure people are treated with dignity and are protected from harm	This outcome was fully met. Currently no issues have arisen which would mean MCA forms or DOL forms had to be considered. Forms are in place should they be needed. There was a basic MCA policy available but additional, more comprehensive information was available online.	Fully met	2
	6.2 Excellent safeguarding procedures ensure people are protected from harm	This outcome was not met. The safeguarding policy should be updated, as it referred to a previous Manager and had no contact details or links to North Tyneside Council. There was evidence in a separate file of NTC's policies and procedures, but the paperwork was not in order and did not have all of the up to date forms from North Tyneside Council. The whistle blowing policy should be expanded to include contact details of who is available to speak to. There was no evidence that information about safeguarding is shared with service users or appropriate others. It is recommended that safeguarding and contact numbers are promoted in the service user guide and in the staff handbook (e.g. numbers for CQC, NTC Safeguarding Team, NTC Gateway/Front Door). It is also recommended that safeguarding should be a regular agenda item in staff meetings and supervisions. Following last year's monitoring visit, the Manager was provided with a copy of the Safeguarding National Competence Framework, however these had not been filled in and staff had not been assessed. Advice was given on the day for the Manager to assess staff member's understanding using this tool. Safeguarding training was out of date and the Manager informed us that staff had been booked on North Tyneside Council's training in November, December and January. However, NTC training department confirmed that there is no record of the organisation or individuals being booked onto this training. The Manager advised that any people entering the building to carry out work are contractors who have been checked and employed by the Owner.	Not met	0
	6.3 Proactive falls prevention practices and procedures ensure that actions are taken to reduce the incidence and impact of falls	This outcome was not applicable to the current service users living at Melrose House.	Not applicable	Not applicable

Main Outcome	Related Outcome Measures	Comments	Outcome	Outcome Score
6. People are prote	6.4 Maintaining a safe environment ensures people are protected from potential hazards	This outcome was met overall. During the visit the tumble dryer broke, and within 24 hours the Owner had replaced it. The Manager of the service reported that the Owner is very responsive to the upkeep of the building and it's contents. There was a very well maintained and clean smoking hut in the back yard, which is a welcome asset to the home. The laundry is currently in an outbuilding where the untreated concreted floor was uneven and difficult to clean. It is recommended that flooring be installed where it is easily cleaned and level, to minimise trips and promote a more hygienic area.	Fully met	2
	6.5 Appropriate and safe equipment ensures people receive safe and dignified care	This outcome was fully met. The Owner has installed a stair lift, which is not currently used by any service users. This was installed with the view that this may be an asset for any future respite or permanent placements. One service user has an electric mobility scooter, and she is supported to have this regularly serviced, put through an MOT and taxed. There was an array of walking frames stored in the back yard, advice was given that they are awaiting being picked up by ALES Joint Loan Equipment Service.	Fully met	2
			Score	**6**
7. People experience improved health and well-being	7.1 People's nutritional needs are comprehensively met and dining is a positive experience for all	This outcome was met overall. Food options are discussed in service user meetings, but it was felt that this could be explored further, asking service users about any future suggestions. It was good to see that service users are encouraged to take part in cooking, alongside one member of staff on day shift.	Fully met	2
	7.2 Effective Health and Hygiene practices minimise the risk of cross infection	This outcome was met overall. The Health and Hygiene policy was written in 2014. There was a structured routine to facilitate service users participating in the cleaning of the home e.g. cleaning rotas, dishes rota, laundry rota, smoking hut cleaning rota. This works well, especially with the service users who benefit from a more structured routine. Speaking to service users during the visit, it was clear that they knew they had responsibilities in helping to keep the home clean and tidy. It is recommended that the Manager signs off the cleaning routines. There was no evidence that larger cleaning jobs e.g. the cleaning of windows, curtains, blinds etc. was being carried out. The laundry is presently situated in an outhouse, with an uneven concrete floor. It was felt that this would be difficult to keep clean, and also would be very cold in winter for staff and service users to access.	Fully met	2
	7.3 Robust medication procedures ensure people receive the right medication at the right time to protect their health	This outcome was partially met. The Medication policy was not specific to Melrose House and should be developed in a number of aspects. It should make reference to errors and omissions being linked with Safeguarding and being recorded as a low level concern. It should also be developed to cover controlled drugs and periodic medication. Administration of controlled drugs has become more of a responsibility at Melrose House as the resident group has become more mental health based and there were several people who do require assistance with controlled drugs. Because of lone working the service cannot ensure two staff are present to administer controlled drugs. It would be good to seek advice from a pharmacist to ensure best practice and compliance with regulations. A contact name has been passed to the Manager in this respect. The possibility of obtaining a second signature should be explored; perhaps being checked when another member of staff is available or involving the resident. Medication is booked in by two staff and audits are carried out by the Manager. For controlled drugs weekly checks should be carried out by two members of staff. In practice appointments for periodic medication are planned in the diary. It would be good to reference this in the policy. There was no photograph on one of the medication records viewed. Four of the five staff have responsibility for administering medication. All of these staff had completed Medication Awareness (Level 2) training within the last 3 years. Two of the staff had had their medication competencies assessed in the last year. The other two staff were new to the team and had had completed their level 2 awareness earlier in the year, so it is recommended that they complete their annual competency before the anniversary of this completion.	Partially met	1
			Score	**5**

Total Scored	**38**
Maximum Score	**58**
Percentage scored	**66%**