Edgbaston Healthcare Limited

Melville House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Melville House is registered with the Care Quality Commission to provide accommodation and support for up to 29 people who require nursing care. The registered manager had recently left the home and the operations manager was present throughout the inspection. The operations manager told us that the home had recruited a new manager who was waiting to become registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 19 April 2016. At that time we identified breaches of three legal requirements. This was because people had not been supported to take their medicines safely and people were not always supported in line with the Mental Capacity Act (2005). The third breach related to Good Governance whereby the provider had not ensured that adequate systems were in place to monitor the safety and quality of care that people received.

After the last inspection, we met with the provider to discuss our concerns about the service. They also wrote to us to say what they would do to meet the legal requirements and to consistently provide a well led service.

We carried out this unannounced focussed inspection on 11 October 2016. We undertook the inspection to check if the provider had followed their plans and to confirm that they were now meeting legal requirements. At this inspection we found that although some improvements had been made to the support people received to take their medicines. Further improvements in terms of medicines management were still needed to ensure that compliance with the regulations would be maintained.

People could not be assured that their rights were upheld by the provider or that the service was being managed in a way that led to improvements in the quality of care people received. We found that sufficient improvements had not been made in relation to MCA and Good Governance and the home remains in breach of these regulations.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Melville House Care Home on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People could not be confident that they would always receive their medicated skin creams as prescribed.

People received some of their medicines safely, however medicines was not always stored safely.

Is the service effective?

Requires Improvement

The home was not always effective.

People did not always have their rights protected in relation to the Mental Capacity Act.

People were not given meaningful opportunities to consent to their care.

Staff did not understand their responsibilities in relation to people's' rights and their capacity.

Is the service well-led?

Inadequate

The home was not always well led.

The provider had failed to improve quality assurance systems in relation to effective monitoring and driving improvements within the service.

The provider had not ensured that staff displayed the right values and behaviours towards people.

People could not be sure that they were supported with safe equipment as this was not checked.

The manager was not aware of all day to day practices within the home and the impact they had on people.

Melville House

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of Melville House on 11 October 2016. This inspection was done to check that improvements had been made to meet legal requirements, as planned by the provider following our April 2016 inspection. The inspection was undertaken by two inspectors. The inspectors spent time watching people go about their daily lives and how staff supported them. The team inspected the service against three of the five questions we ask about services: 'Is the service safe, effective and well led?' This is because the service was not meeting some legal requirements within these areas.

We reviewed action plans sent to us from the provider before the inspection and other information we had received from them such as notifications. During our inspection we spoke with three people who used the service, one relative, four staff and the operations manager. We looked at the providers records in relation to their quality assurance systems, medicines and some care records. After the inspection the provider sent us some other information that we had asked for.

Requires Improvement

Is the service safe?

Our findings

When we inspected in April 2016 we found the new system of electronically recording when people had taken their medication was not effective and the registered manager could not be sure that people were safely receiving their medicines. Since that inspection the provider had made changes that ensured that most medication management had improved.

At this inspection we found that the provider had returned to a manual system of recording medication and this was being done effectively. We found that there were guidelines in place to tell staff when people should have any medicines on an, 'as and when required' basis and any non-regular medications such as antibiotics were clearly recorded as administered. Records also showed the strength, form or dose of the medication that had been given. Medication records in respect of tablets were completed and signed and the records provided enough information to support staff to administer medication as required.

We found that people could not be sure that they were having their skin creams applied as had been agreed or directed by their doctor. A relative told us, "[My relative] needs their skin cream more than once a month." We looked at the persons care records which showed that the person had not been supported to have their cream applied as prescribed after every shower or bath. When we spoke with staff they were not clear about when the person needed their skin cream. For another person there were gaps in the records about their skin creams which failed to indicate that they had received their medication as prescribed, with numerous blank spaces where staff had not recorded that it had been administered.

The provider could not be sure that all medicines were stored at the right temperature. We saw that there was a specific fridge which was locked and used to store some medicines which needed to be kept very cool. However the majority of medication was stored on trolleys which were secured and located in warm communal areas within the home. There was no recording of the temperature of medicines within the trolleys. Failure to store medicines within an acceptable temperature range could affect their effectiveness.

Following our visit to the home, a community pharmacist reported that the ordering of some medication was subject to delays which may have meant that some people did not receive their medicines in a timely manner. The manager had not established an effective system with the community pharmacist to ensure that people's medicines were received in sufficient time. The manager told us that this was being addressed.

At our inspection in April 2016 we saw that the medication policy had not been reviewed for many years, and at this visit we were assured that it had been recently updated. However the policy was not made available to either the inspection team, or on a separation occasion, to a pharmacist who was conducting a medication audit.

Staff knew how to support people to take their medication appropriately. We observed that people's medicines were administered by the nurses at the service and a count of two people's medication indicated that they had received their medication as prescribed. Nurses kept their registration up to date and this was

monitored by the provider. This is important to ensure nurses are aware of current best practice. Staff who administered medication told us that had received appropriate training. Nurses and care staff told us they had not had any observations or checks on their competency to administer medication undertaken. The manager told us this was going to be introduced. This meant that while there were some systems in place to ensure staff had training and skills to safely administer medication.

Requires Improvement

Is the service effective?

Our findings

During our last inspection we found that the service had not ensured that people's rights were upheld to be supported and cared for in line with the regulations and the Mental Capacity Act. This was a breach of Regulation 11 of the Health and Social Care Act (2008) Regulations 2014, Need for Consent.
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).

During our last inspection we found that the home had not applied for DoLS for people. We found during this inspection the provider had made some DoLS applications for people as required. The improvement was not consistent however, and we found that where DoLS had been authorised they had not been implemented by the home, and some people did not have their rights upheld while the provider was waiting for the outcome of an application. This meant that some people had not been supported in line with the MCA.

Records showed that DoLS authorisations had been received by the home, but these were not referenced in people's care plans to make sure that staff knew how to support people correctly. For example one person's authorisation stated that they were not at liberty to leave the home, when we looked at the persons care records this was not referenced in any way. Care staff we spoke with were unaware of what liberties the person could or could not be deprived of. In another instance, an application had been made by the home but people's rights were not protected while the application was being processed. The impact of this was that a person was not consulted with in an appropriate manner. They had not been involved in the decision about whether or not to move from having their own bedroom to moving into a shared bedroom. We raised this concern with the manager who did not have evidence that a best interest decision had taken place. We saw that a DoLS application had been made for this person, but not yet authorised. The person or their representatives had not been given the opportunity to be involved in the decision around room changes.

We saw that where capacity assessments had been undertaken, they were unclear and undated, and that where best interest decisions had been made they had not been reviewed or updated as people's needs changed. Some people did not have their rights upheld in line with the principles of the mental capacity act. We noted that the home had produced new paperwork to improve this area but at the time of our inspection it had not been implemented.

People were not consistently asked for their consent when staff began to support them. Throughout our inspection we saw many examples of people being requested by staff to return to their seats or move to or

from certain areas within the home. Most of the requests by staff were done kindly but very persistently, we saw that although people did not verbally refuse they repeatedly tried to leave the area where they had been directed to by staff. We saw that people were always directed back to one of the lounge areas where a member of staff sat and observed them. In one instance we saw a member of staff laughing unkindly at a person when redirecting them. We saw that people were not free to move about the home or given a real choice of where they wanted to be.

Staff had received training around mental capacity, but only a small number of staff had had any refresher training since 2014. We found that not all staff had a clear understanding of how the mental capacity act applied to the people they were supporting. Staff could not tell us which people had authorisations in place or might need to be deprived of their liberty. Staff also displayed a poor understanding of how identify if people were giving consent and how people might be supported to consent to their care in a meaningful way.

The provider had not ensured that they operated in accordance with the Mental Capacity Act and remains in breach of Regulation 11 of the Health and Social Care Act (2008) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

During the previous inspection in April 2016 we had found that there were ineffective systems in place to monitor the quality of the service, and drive forward improvements. We determined that the home was in breach of Regulation 17 of the Health and Social Care Act (2008) Regulations 2014, good governance.

In April 2016 we noted that audits of medicine management systems and risk assessments relating to peoples care needs and equipment used in the home were not effective and failed to identify and address the issues identified. We also found that analysis of incidents and accidents had not taken place in order for the service to learn from issues and concerns.

During this inspection we looked at areas of good governance within the home and how the home made changes to drive improvements. The previous registered manager had not consistently returned notifications to us as they were required to do by law. It was welcoming to note that the current operations manager was aware of their responsibilities in relation to CQC and had returned notifications to us as required.

We found significant shortfalls in aspects of how the service was led. Systems in place had failed to identify and ensure that people were treated with dignity. We saw that staff did not understand the principles of quality assurance and there was a lack of clear communication between staff and managers regarding day to day events within the home. For example, the manager was not aware of the system in use by staff in relation to some aspects of people's personal care. We asked staff about how and when people received baths or showers and were shown a 'bath rota', detailing who was bathed on certain days. Three care staff confirmed that people were given baths or showers in line with the rota. During our inspection a relative told us that that they needed to shower their relative when they went home for visits. This was because the service had not ensured that person was supported to maintain their appearance and to be consistently supported to be clean and comfortable. The process was difficult and dangerous for both the person and the relative, as they did not have the correct equipment to support the person to bathe at home safely. Only showering or bathing a person in line with a rota failed to ensure that people received personalised care to meet their needs or preferences. We brought this to the attention of the manager who was unaware of this practice that happened on a day to day basis within the home.

In our inspection of April 2016 we noted that medicine management systems were not being audited effectively. Since that time the home had returned to a manual method of administering and auditing the administration of medication which was now effective. However, other aspects of medicines management had not been monitored well. We found that people did not have their skin creams as prescribed and some medicines may have been less effective as the provider could not be sure they had been kept within an acceptable temperature range.

At the inspection in April 2016 we found that mattress pressures on air mattresses and bed rails were not being used consistently in line with national guidance. We were not assured that people were kept safe when using specific equipment, including air mattresses and bed rails. At this inspection we found that

although progress had been made there were still examples of records that had not been updated to reflect that checks and audits were being undertaken. We found that the provider had not implemented effective auditing systems that addressed these concerns.

We found that there were very few effective systems in place that enabled the provider to monitor and review if improvements to the service had occurred as planned. The manager showed us the systems that had been introduced which we saw were not working well. For example we saw a system to monitor the number of supervisions that had taken place for staff at the home. This indicated that no supervisions had taken place since our last inspection. After our inspection the manager provided us with details of supervisions that had been held. However the auditing processes had not identified whether or not the monitoring records were accurate.

In our inspection of April 2016 we saw that there was no analysis of incidents and accidents in order for the service to learn from previous concerns. We looked at the incident recording again and saw that during a period from May 2016 to September 2016, a number of people had fallen 18 times and only 10 of those falls were logged in the accidents book. Of the 10 falls recorded in the accident book, three people required medical treatment. In most cases follow up actions to keep people safe had not happened, with only one person being referred to a team of people who specialise in helping people to manage falls and there were no updates or changes made to care support plans. There was no analysis of the accidents to look for trends and to check if any accidents could be prevented or were avoidable.

Since the inspection in April 2016 the provided had submitted regular updates on action they had taken in response to our inspection report and its findings The provider identified that they had not made as much progress in the area of good governance of the home as they had anticipated. The manager advised that they were keen to continue working on improved auditing and monitoring processes which were ready to be introduced and used in the home to improve the quality of the service provided.

During this inspection we found that very little progress had been made to improve and address the known issues in respect of monitor and improving the service. The home was still in breach of Regulation 17 of the Health and Social Care Act (2008) Regulations 2014, good governance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that they operated in accordance with the Mental Capacity Act

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We had found that there were ineffective systems in place to monitor the quality of the service, and drive forward improvements. We found that very little progress had been made to improve and address the known issues in respect of monitoring and improving the service.