Oakridge Care Homes Limited

Melbourne House

Inspection report

23-35 Earlsdon Avenue South
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Coventry
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Tel: 02476672732

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06 April 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Melbourne House is a residential care home providing personal care for up to 33 older people aged 65 and over including those living with dementia. Accommodation is spread over three floors which are accessible by a lift.

People's experience of using this service and what we found
People did not receive safe care. Staff did not always know about people's needs and had not completed all the training they needed to provide safe care. Staff competency had not been sufficiently assessed following training to confirm their learning and understanding.

Risks associated with people's care were not promptly identified and managed. People's nutritional needs were not effectively managed to ensure people received sufficient nutrition and the support they needed. People's care plans were either not available, lacked information about people's needs or did not always contain accurate information to help staff support people safely. Staff did not have full access to information about people on the electronic handheld devices they used to read about people's needs and record the care and support they provided to people.

Infection prevention and control was not safe. Improvements were needed to maintain cleanliness across the home including equipment.

Medicines were not always managed safely in line with best practice guidance to ensure people's healthcare needs were managed effectively. Medicine records lacked information and arrangements for the administration of medicines at night were not effective.

Governance systems, and management and provider oversight of the service, were inadequate. Systems and processes designed to identify areas of improvement were ineffective. The provider's policies and procedures did not always provide staff with the guidance they needed. Audits and checks were either not completed or lacked detailed information. They had not identified the concerns we found. This demonstrated lessons had not been learnt since our last inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 9 November 2019).

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 12 July 2019 where a breach of legal requirements was found. The provider completed an action plan after the inspection to show what they would do, and by when, to improve meeting nutritional and hydration needs of people.

This inspection was prompted in part due to concerns received about lack of risk management associated with people's care, infection control, continence, nutrition, and wound management. There were also concerns raised around staff training and competence. This focused inspection also checked the provider had followed their action plan following the last comprehensive inspection to confirm if they now met legal requirements.

We undertook a focused inspection to review the key questions of Safe, Effective and Well Led only and this report only covers findings in relation to these key questions.

The ratings from the previous comprehensive inspection for those key questions that were not looked at on this occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Melbourne house on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches in relation to risks associated with people's care including management of people's nutrition, and management oversight of the service. The provider had not ensured effective systems and processes were in place to monitor the quality and safety of the service and drive improvement.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We met with the provider prior to this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is Inadequate and the service is therefore in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service well-led? The service was not well led.	**Inadequate**

Melbourne House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This focussed inspection was carried out by five inspectors. On 06 April 2021, two inspectors visited the home. Three inspectors spoke with staff over the telephone to gather feedback on their experience of the working at the service.

Service and service type
Melbourne House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 60 minutes notice of our inspection visit because the service was inspected during the coronavirus pandemic, and we wanted to be sure we were informed of and followed the provider's coronavirus risk assessment for visiting professionals, before we entered the building.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with 13 staff members including the provider, deputy manager, senior care workers, care workers, domestic staff and the chef. We observed how people were supported in the communal areas of the home.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We met with the provider to seek clarification from the provider regarding evidence found and actions planned to improve the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Information we received prior to our visit indicated people did not always receive safe care because some risks associated with their safety were not managed well. We found this to be the case during our inspection.

● One person had pressure ulcers, sores on their body, and dry skin, in addition to multiple health conditions. The person told us they suffered with itchy skin which made them scratch. There were no care plans in place to guide staff on how to support this person's needs. Staff were not fully aware of the person's needs which demonstrated how the lack of records impacted on this person's care.

● A second person at high risk of falls had recently fallen and sustained a fracture. There was no care plan in place to provide instructions to staff on how to prevent, or minimise, the risk of them falling again. We were told a sensor mat provided to alert staff at night if the person moved was not used consistently to manage this risk.

● A person with a pressure ulcer and skin damage had been prescribed equipment to support their skin to heal. There were no records to inform staff how to use the equipment. Staff told us the equipment needed to be used during the day, but we observed this did not happen consistently. This placed the person at risk of prolonged skin damage.

● There were risks associated with the environment. For example, an there was an open staircase which had not been sufficiently secured. There were people living with confusion or dementia who potentially could access the stairs putting them at risk of falls. A staff member told us there was a person who sometimes used these stairs at night which they did not consider safe.

● Risks associated with people's care were shared with the Local Authority by CQC to enable these to be assessed and acted upon as required.

Using medicines safely

● Processes to support safe medicine practice needed to be improved.

● Medicine records were not sufficiently clear to support safe medicine practice. One person had been prescribed pain relief patches. Manufacturer guidance states patches applied to the skin should be rotated to minimise the risk of skin irritation. Records did not show where the patches had been applied to confirm staff were applying the patches as prescribed.

● Prescribed creams had not been applied to people's skin as prescribed to relieve their skin conditions including, sore and dry skin. One person's cream had not been applied correctly for 18 days during one month. Another person had no medicine chart to show it had been applied at all and staff were not aware that a cream had been prescribed for them. This placed people at risk of prolonged discomfort and infection.

● One person had been prescribed lubricating eye drops used to relieve dry and sticky eyes. Medicine administration records showed on 24 days during one month the person had not received this medication as prescribed placing the person at risk of discomfort.

Preventing and controlling infection
● We were not assured that the provider's infection prevention and control policy was up to date in line with current guidance to support staff in the management of safe infection control practice.
● People were not admitted safely into the service. One person had moved into the home during the inspection without self-isolating as required. Therefore, current guidance was not being followed and the risk of transmitting Covid-19 was increased. Immediate action was taken to address this shortfall.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the home were dirty and cleaning schedules were either not in place or were ineffective. Plans were in place to drive forward improvement.

Learning lessons when things go wrong
● Actions taken following the last inspection showed insufficient action had been taken to improve the home and the quality of care provided. This demonstrated lessons had not been learnt.
● The lack of management oversight meant areas needing improvement were not identified to ensure lessons could be learnt.

Systems and processes to safeguard people from the risk of abuse
● People were not safeguarded from the risk of abuse as systems and processes to keep people safe were not always followed.
● Records were not consistently maintained by staff to demonstrate people's care was managed safety and they were not placed at risk of harm. For example, one person had a wound that needed medical attention and staff were not aware of this. Records had not identified the wound. This placed the person at risk of neglect.
● People told us they felt able to tell staff if they didn't feel safe. One person told us, "I would tell one of the carers if something was wrong, I think they would listen. I would tell my [family member] if no one was listening."

Staffing and recruitment
● The provider was unable to demonstrate that all staff on duty had the skills and knowledge they needed to meet people's needs and provide safe care. Some staff demonstrated gaps in their knowledge in respect of risk management, infection control and safe medicine management.

There was a failure to provide safe care and treatment to people. This was a breach of Regulation 12(1) (2) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People felt overall their needs were met and we saw there were sufficient numbers of staff on duty to meet people's needs.
● Recruitment records showed employment checks had been completed prior to staff starting work at the home to ensure staff were safe to work with people.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

At our last comprehensive inspection, the provider had failed to demonstrate people's nutritional needs were met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 14.

● People at risk of malnutrition did not receive their prescribed dietary supplements. Records lacked information to show people were provided with suitable and nutritious food and hydration to maintain good health. People were not always supported as needed.
● One person at risk of choking had consistently lost weight over a five-month period. The person was to be provided with fortified (added calories) meals and nutritious snacks. We found no evidence to show the person received these. The person's nutrition care plan and risk assessment contained conflicting information with one stating 'bite sized' meals and other stating pureed food. This placed the person at risk of receiving food that was not safe and suitable for them.
● One person told us," I would like more drinks; we get drinks with meals and the tea trolley in the afternoon, but you can't really help yourself to a drink. We don't have any meetings to talk about things like that."
● We saw one person was seated in a slouched position in a wheelchair at a dining table which was not a safe position for them to eat. No staff member recognised this. The person attempted to eat their pureed meal and repeatedly dropped it over their clothes resulting in them eating very little. Also, the meal the person ate was not the meal staff had recorded they had eaten. This meant records could not be relied upon to assess if the person was eating enough to sustain good health.

This was a breach of Regulation 14 (1) (4) - Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care records contained limited information regarding people's needs and choices. For example, one person had no care plans in place despite living at the home for several months which meant staff didn't have the information to effectively support the person's needs and choices.

● Staff told us people's choices were not always respected. For example, staff told us people were not always given a choice regarding the time they got up. One staff member told us, "Night staff wake up eight or nine people in the morning. The night staff wake people, so we have enough time to get everything done." The staff member went on to explain people were encouraged to go to bed before the night shift staff arrived for the same reason.
● People gave mixed feedback regarding their choices being respected. For example, one person told us, "Staff are pleasant enough. I only have the ladies shower me and dress me which is what I want. I was asked my preference and I said only female staff." Others said they were not given a choice of meals at lunchtime. We saw a person who was supported in a wheelchair to the dining room was not asked where they would like to sit and were not asked if they wanted to get out of the wheelchair to sit in a dining room chair to eat their meal.

Staff support: induction, training, skills and experience
● Staff had access to some training, but this was not effectively organised to maintain staff competencies and understanding.
● Staff did not receive sufficient training to support people's specific healthcare needs such as nutrition and continence. Not all staff had completed dementia care training, so they knew how to respond to people's needs. One staff member said of dementia training, "I don't remember what was in the training, but you just get to know what people are like and what they prefer."
● There were no staff on night duty that felt confident to administer medicines. One staff member told us, "Staff have been told they can (administer medicines) but will not do it and they will wait for a senior to start on the day shift."
● The timescale for refresher training in relation to training considered essential, such as moving and handling people, was three years in most cases. Staff told us they could not recall some of the training they had completed. The training matrix showed no additional training had been provided during the COVID-19 pandemic regarding infection control to support staff, a staff member told us they had not completed additional COVID-19 training during this time.

Adapting service, design, decoration to meet people's needs
● The premises had not been fully adapted to take into consideration the safety and needs of people who lived there. For example, the open staircase (as described in Safe above) which had not been secured.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● MCA assessments and DoLS applications had been completed for some people. However unclear records

meant it was not possible to evidence DoLs applications had been completed as necessary for all those as required.

● Care records did not always make it clear where people lacked capacity to make decisions to ensure staff would know to support them in decision making.

● Staff gave conflicting responses when asked about people who lacked capacity. One staff member said nobody in the home had capacity to make their own decisions. However, another staff member stated, "Some people can't do that here (make their own decisions) and they have a DoLS in place."

● Staff knew people had the right to refuse care and make their own decisions and there was some evidence unwise decisions were respected where this did not impact on their safely.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People were put at risk because the provider failed to ensure suitable quality assurance checks were in place. For example, care plans were not checked for accuracy and lacked information to support staff in meeting people's needs safely. Medicine's checks were not sufficient to ensure they were safely managed. Cleaning checks were not effective to ensure the home was clean and safe to prevent and control infection.
- One staff member described working at the home as "chaotic" and described the home as needing more structure. They went on to say, "I think there is a lot that needs to be improved but they don't have a lot of full-time staff. I hope once they get full staff then things will fall into place."
- Whilst there was a registered manager in post at the time of our inspection, they were taking a planned absence. The deputy manager was therefore working in an acting management role supported by the provider.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff did not have full access to people's care records on their electronic hand-held devices to enable them to access information they needed about people to support person centred care.
- Staff had gaps in their knowledge of people's needs which meant support people needed was not always provided.
- People told us they were not involved in any meetings at the home to discuss the service or their care. One person told us, "Never had a meeting to discuss what goes on around here. No meetings at all."
- The provider had not fully established practices and procedures to ensure peoples equality characteristics of disability in respect of dementia care were being considered and supported in line with their needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The provider did not have an effective system in place to analyse risk information in relation to people's care which meant they did not have a clear overview of risks, themes and trends. Opportunities to improve the quality of care for people, were missed.
- The provider had not ensured the policies and procedures in place were followed by staff consistently.
- Systems for learning from incidents and poor practice had not been adequately implemented which meant people continued to experience poor practice and outcomes. For example, people had experienced

skin damage and records lacked information about this. Records continued to demonstrate a lack of actions in response to skin damage.

There had been a failure to assess, monitor and improve the quality, safety and welfare of service users and others who may be at risk. This was a breach of Regulation 17 (1) (2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A sample of accident records were reviewed. Safeguarding referrals and CQC notifications had been submitted as required.
● The provider had arranged for the deputy manager to take over management duties in the absence of the registered manager.

Working in partnership with others
● While the management team had developed links with a variety of professionals, it was not always clear from records what advice had been provided to ensure staff followed it to help people's health and wellbeing improve.
● The provider was working with a care home consultant and the local authority to identify where their systems had failed with the aim of improving their systems and processes and the quality of their service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk associated with people's health and safety were not sufficiently assessed and managed to ensure people received safe care. People were not protected from the risks associated with the spread of infection. Arrangements in place for the safe management of medicines were not sufficient.

The enforcement action we took:

Condition imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Peoples nutrition and hydration needs were not met.

The enforcement action we took:

Condition imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor and improve the quality of the service for people were inadequate.

The enforcement action we took:

Condition imposed on the providers registration.