Oakridge Care Homes Limited

Melbourne House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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 passenger lift. At the time of our inspection there were 12 people living at the home. One of those people was in hospital at the time of our visit.

People's experience of using this service and what we found
Lessons had not been learned, because the provider continued to fail to ensure people living at Melbourne House always received safe, high-quality care. Whilst some progress had been made since our last inspection to benefit people, progress to implement all the required improvements was too slow. The provider remains in breach of the regulations and as a result people remained at risk of harm.

Some of the provider's quality assurance systems remained ineffective and had failed to identify the concerns we found. In addition, the continued lack of managerial oversight meant the provider nor registered manager could assure themselves people had received the care they needed to keep them safe. Some known risks associated with people's care had not been assessed and care records had not been updated to ensure staff had the accurate information they needed to provide safe care, consistently. Environmental risks had not always been identified and managed well, and aspects of fire safety continued to require improvement. Immediately after our inspection visit the management team took some reactive action to improve safety.

Areas of medicines management including prescribed creams still required improvement. Despite our findings people told us they received their medicines when they needed from trained staff. New medication audits were being introduced at the time of our visit in an attempt to improve medicines safety.

Not enough improvement had been made to ensure the risks associated with some people's nutrition were well managed. However, some improvement had been made in this area because people spoke positively about the quality and availability of food and drinks. Staff knew what people liked to eat and drink and people were supported to eat their meals and consume drinks when needed.

The provider had repeatedly failed to ensure all of their staff had completed all of the training they needed to carry out their roles effectively. The registered manager took action to address this shortfall in response to our feedback. Staff spoke positively about their training and the induction for new staff had improved since our last inspection.

People were happy with the care and support they received. People told us they liked the staff and they felt safe living at Melbourne House. Staff and the management team understood their responsibilities to keep people safe. Enough staff were on duty to meet people's needs in a timely way and recruitment checks had been strengthened since our last inspection to help ensure staff were suitable to work with people.

People liked their living environment and the design and adaptation of the building met people's needs. Staff spoke positively about the culture at the home and enjoyed their jobs. Feedback gathered from people was listened to. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Overall, the prevention and control of infection at Melbourne House had improved since our last inspection and visits to the home took place safely. The management team demonstrated their ongoing commitment to working in partnership with other organisations to improve outcomes for people. Feedback from people and their relatives confirmed people had access to health care professionals when needed.

The management team welcomed our inspection. They understood their responsibility to be open and honest when things went wrong.

Rating at last inspection and update
The last rating for this service was inadequate (published 03 November 2021). and there were multiple breaches of regulations. At this inspection not enough improvements had been made and the provider was still in breach of regulations.

Why we inspected
Due to the seriousness of the concerns we had identified during an inspection in April 2021 we imposed conditions on the providers registration to focus their improvement activities. This focussed inspection was carried out to check the provider had made necessary improvements and was compliant with the regulations.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence the provider needs to make further improvements. Please see the safe, effective and well-led sections of this full report. For key questions not inspected, we used the ratings awarded at previous inspections to calculate the overall rating.

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 and Recommendations
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 when it is necessary for us to do so.

We identified continued breaches in relation to safety and governance. As a result, the conditions we had imposed on the provider's registration remain in place.

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 will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for the service has remained inadequate based on the findings of this inspection and therefore the service remains in special measures. We will keep the service under review, and we will take action in line with our enforcement procedures. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. 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.

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

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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 Health and Social Care Act 2008.

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
The inspection team consisted of three inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Melbourne House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Melbourne House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from the local authority who work closely with the service. 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.

During the inspection
We spoke with six people who lived at Melbourne House and three people's relatives to gather their experiences of the care provided. We spoke with nine members of staff including the registered manager, a domestic assistant, three care assistants, two senior care assistants, the cook and the activities coordinator. We also spoke to the care consultant and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed the care and support provided to help us understand the experience of people who could not talk to us.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and training data. We viewed a variety of records relating to the management of the service. We received information from the registered manager to demonstrate the actions taken to improve safety and to validate the evidence found.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

At our two previous inspections the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) 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 12.

- Since 2014 the provider has not ensured people living at Melbourne House have always received safe care. Whilst some action had been taken since our last inspection to improve safety, progress has been too slow, and aspects of the service remained unsafe.
- Some known risks associated with people's care had not been assessed. One person had painful leg ulcers and the associated risks had not been assessed. Whilst permanent staff told us they knew how to provide safe care agency staff who might not know the person well worked at the home. That meant important information was not documented to ensure the person always received pain free care.
- Care records had not always been updated when people's needs had changed to ensure they received safe, consistent care. A GP had made a significant change to the way a person's health condition was managed on 11 May 2022. Whilst staff were aware of this change care records had not been updated to reflect this.
- Another person was at high risk of falling and previous falls had resulted in them being injured. Care records instructed staff to complete hourly checks of the person during the night. Records did not confirm the checks had taken place hourly. That meant the provider could not assure themselves the person had received the care they needed to keep them safe. In response to this the registered manager told us the checks had taken place, but staff had not recorded the checks correctly.
- Environmental risks were not always identified and managed well. We saw two windows fitted with restrictors that did not conform to current Health and Safety requirements. This placed people at risk of harm because the windows could not be opened and used as an escape route, if required, in the event of a fire.
- Water taps in 18 vacant bedrooms had not been flushed through with water at least weekly in line with Health and Safety requirements which placed people at risk. Running water through taps that are not in regular use is important to reduce the risk of Legionella and other bacterial growth.
- At our last two inspections aspects of fire safety had required improvement. We found similar concerns at this inspection. People's personal emergency evacuation plans (PEEP's) contained inaccurate information.

For example, one person's bedroom number was incorrectly documented. This meant inaccurate information would have been provided to the emergency services in the event of the person needing to be evacuated from the home. This placed the person at risk of harm.
● An emergency contingency plan was not in place in line with the provider's fire procedure. This meant staff did not have the information they needed to keep people as safe as possible in the event of them not being able to return to their home following, for example, a fire. We brought this to the attention of the provider for remedial action to be taken.

Care and treatment continued not to be provided in a safe way. Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately after our inspection visit the management team took some reactive action to improve safety, including updating people's risk assessments, implementing an emergency contingency plan, replacing unsuitable window restrictors and flushing water taps in vacant bedrooms.
● Despite our findings people told us they felt safe living at the home. One person said, 'Yes, enough staff on duty to keep us safe. We trust them." Relatives spoken with supported this viewpoint.
● Staff completed safeguarding training and explained what they would do if they thought someone was at risk of harm. One staff member said, "If a resident disclosed something, like someone had shouted at them it's abuse. I would tell the manager." Another told us, "If I saw a bruise or sore skin, I would document it, do a body map and tell the senior." Those discussions demonstrated improvement had been made in this area.
● The registered manager understood their responsibility to keep people safe. They had shared information with the local authority and CQC when required.

Learning lessons when things go wrong
●The provider continued to miss opportunities to learn lessons. Despite the provider's attempts to drive forward improvements aspects of the service remained unsafe. The provider remained unable to demonstrate compliance with the regulations.
● Accidents and incidents that occurred were recorded but the providers systems did not always demonstrate what actions had been taken to prevent recurrence.

Using medicines safely
● At our two previous inspections the provider had assured us the safety of medicines management would be improved. Whilst we found some improvements had been made, more needed to be done to ensure the management of prescribed creams and eye drops was always safe. For example, not all prescribed creams in use had their dates of opening recorded in line with best practice guidance. This is important as creams can lose their effectiveness, or may not be safe to use, if they are not administered in line with manufacturer's instructions.
● The registered manager described medicines management at Melbourne House as, 'a work in progress'. New medication audits were bring introduced at the time of our visit in an attempt to improve medicines safety and strengthen managerial oversight in this area.
● People told us they received their medicines when they needed them. Staff administering medicines had received training in safe medicines management and their competency to administer medicines safely had been assessed by their managers.

Staffing and recruitment
At our last inspection sufficient numbers of suitably competent and skilled staff were not on duty to meet

people's needs. This a was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● We saw, and people told us, enough staff were available to meet their needs in a timely way. One person said, "When you press the call bell the red-light flashes and the staff come in. I will show you." The person then activated their call bell and staff promptly entered their bedroom to offer them assistance. A relative commented, "Staffing levels are usually pretty good." This demonstrated improvements in relation to staffing had been made.
● People liked the staff. One person said, "I know the staff. They are all very pleasant and that includes the agency staff. We have a chit chat and what I really like is we can have a bit of fun. They are helpful." One relative commented, "I find staffing fine."
● A sample of staff rotas confirmed the number of staff on duty corresponded with the number of staff the provider had assessed were needed, to meet people's needs.
● Following our previous inspection the provider had strengthened their recruitment checks to help ensure staff were suitable to work at the home.

Preventing and controlling infection
● We were somewhat assured the provider's infection prevention and control policy was up to date. However, infection prevention and control checks were not always completed in line with the provider's expectations and policies.
● We were somewhat assured the provider was making sure infection outbreaks can be effectively prevented or managed. The checks of water were not robust.
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.

Visiting in care homes
There were no visiting restrictions in place. Relatives we spoke with told us they could visit at any time.

Requires Improvement

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At our two previous inspections 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

● Despite the provider's attempts to drive forward improvement in this area more needed to be done to demonstrate nutritional risks were always well managed. Completed care records did not consistently evidence risk assessments and care plans had been followed by staff to manage nutritional risks. In addition, care records did not evidence the amount of food and fluids some people had consumed was sufficient to maintain their health.
● People provided positive feedback about the quality and availability of food and drinks. Comments included, "They (staff) tell me what's on offer. I told them I wanted two rashers of bacon, two eggs some mushrooms and one piece of white toast. I got it. I always get what I ask for," and, "I like the chicken pie, its lovely, portions are big, and they (staff) are always topping up my drinks."
● Relatives told us people ate enough food and drank enough fluid to maintain their health. Comments included, "They (staff) do seem to make an effort with drinks between meals, I have seen them give (Name) drinks," and, "No concerns, no complaints."
● We saw a variety of food and drinks were provided to people throughout our visit which demonstrated improvements had been made. In addition, staff were attentive and provided the support and encouragement people needed to eat their meals and consume drinks.
● The cook prepared fortified foods and drinks for people who needed them. Food fortification is when extra nutrients are added to food and drinks to increase their calorific value and if consumed can help to reduce the risk of weight loss. One staff member said, "(Name) usually likes coffee. They are not keen on cold drinks but will sometimes have mighty mousse with encouragement." Fortified foods including 'mighty mousses' were provided and eaten by some people during our visit.

Staff support; induction, training, skills and experience
● At our last inspection staff had not completed some of the training they needed to meet people's specific needs. We found further improvement was required to train staff, so they had the skills to support people

safely. Two people had urinary catheters but some staff who provided their care had not completed catheter awareness training in line with the providers expectation. When we discussed this with the registered manager, they arranged for staff to complete the training by 19 June 2022. Despite this failure people told us they were happy with the support they received to manage their catheters and guidance was in place to help staff to provide this care including how to empty urine bags correctly.

● Relatives provided mixed feedback as to whether staff had the skills, they needed to provide effective care. Comments included, "Yes, training seems absolutely fine," and, "Overall staff seem properly trained but I do notice the odd new member of staff isn't as skilled. Maybe that's because they are new."

● Previously the induction of new staff was not linked to the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff in health and social care. At this inspection induction had been improved and some staff had completed the Care Certificate.

● Staff spoke positively about their training. One staff member said, "I liked the hoist training. We put ourselves in people's shoes to see what it's like to be hoisted. It was good to do that."

● Staff told us they had one to one and team meetings with their managers to help support them in their role and gave them opportunities to reflect on their practice.

Adapting service, design, decoration to meet people's needs

● The design and adaptation of the building met people's needs. At our last inspection a staircase accessible to people was unsafe. We saw action had been taken which reduced the risk of people falling down the stairs.

● People liked their living environment which included an accessible rear garden, a communal dining room and two lounges. A passenger lift was available for people with mobility issues to use to access the three different floors of the building.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People and those closest to them had been involved in an assessment of their needs prior to them moving into Melbourne House.

● Despite care records not always containing accurate information, agency and permanent staff members told us electronic care records had been made more accessible to them since our last inspection, which helped them to understand people's needs and choices.

● People told us they were offered choices and staff respected the choices they made. Comments included, "I choose what to do, I prefer to stay in my room," and, 'I like to sit at one place at a time, always the corner, they (staff) know what I like."

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.

● The provider was compliant with the MCA.
● People told us staff sought their consent before they provided any assistance. We saw that happened.
● When required people's capacity had been assessed and their care records had been improved making them clear whether or not people had capacity to consent to specific aspects of their care.
● Best interest decisions had been made when needed which demonstrated people's rights were upheld.
● Authorisations to deprive people of their liberty had been submitted correctly when people needed restrictions placed on their care, to keep them safe.
● Staff had completed training to help them work within the principles of the Act.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Feedback from people and their relatives confirmed people had access to health care professionals when needed. For example, two people explained they had requested to see a chiropodist. The registered manager was aware of this request and a chiropodist was due to visit the home shortly after our visit.
● Staff contacted health professionals including district nurses and GPs for advice and guidance if they were concerned about people's health and well-being.

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last two inspections the provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) 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 17.

● Since 2014 we have inspected Melbourne House on eight occasions. At each of those inspections the provider has failed to achieve an overall rating of good. Good care is the minimum that people should receive. This repeated failure demonstrates lessons had not been learned.
● The leadership and governance continued to fail in supporting the delivery of high-quality, safe care to benefit people. This is the third consecutive time this key question and an overall inadequate rating had been awarded to the service. Melbourne House remains in special measures.
● The provider has a history of not meeting the regulations. They have remained in breach of the regulations in relation to safety and good governance since July 2019. In addition, the positive conditions we imposed on the providers registration following our inspection in April 2021, to focus improvement activities, has not driven the provider to sufficiently improve the quality of their service. Whilst we acknowledge some improvements had been made, at this inspection people remained at risk of harm.
● Some quality assurance systems remained ineffective and had failed to identify the concerns we found. That meant opportunities to improve safety and learn lessons had been missed. Despite occupancy at the home being low, quality checks had not ensured environmental risks had been identified and mitigated and aspects of fire safety continued to require improvement. Checks of care records had not resulted in information about people being updated. Some known risks associated with people's care continued not to be assessed to mitigate risks.
● Continued lack of managerial oversight meant the provider could not assure themselves people had received the care they needed to keep them safe. For example, records did not confirm risks associated with poor nutrition and falls were always well managed.

Systems were not operated effectively to assess, monitor and improve the quality and safety of the service. Accurate, complete and contemporaneous records in respect of each service user were not maintained. This

was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The nominated individual told us more improvements were planned. A new external management consultant had been sourced to support this work.
● The latest CQC inspection rating was on display in the service and was available on the provider's website. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Whilst the continued breaches of the regulations evidenced good outcomes for people were not always achieved, people told us they liked living at Melbourne House. People and their relatives knew who the registered manager was, and they spoke positively about the staff. Comments included, "Overall, the staff seem to care, it's a friendly and happy place," and, "To be fair the staff are good, and the care has got better."
● Staff spoke positively about the culture and they enjoyed their jobs. One staff member said, "It's a nice place, I look forward to coming to work. Staff are nice and friendly. I have meetings with the manager and the owners, they do listen to us."
● The provider had followed government guidance to support safe visiting to the home. Relatives felt the management team and staff engaged well with them and told us they were satisfied with the care provided to their loved ones.
● The activities available to people to occupy their time had improved since July 2021. An activities coordinator had been employed and people chose to take part in activities during our visit. The activities coordinator told us they were in the process of building links with local community groups including schools and places of worship to benefit people.
● Feedback gathered from people was listened to and acted upon. Foods including steak pie and cauliflower cheese had been to be added to the food menu in response to people's requests. The care consultant explained quality questionnaires were in the process of being sent out to people, relatives and staff at the time of our visit. They explained any feedback gathered would be analysed and if necessary, action would be taken in response.

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; Working in partnership with others
● The management team consisted of the nominated individual and the registered manager. They welcomed our inspection visit and they took some action in response to our inspection feedback.
● The management team understood their responsibility around the duty of candour including sharing information with other agencies and being open and honest when things went wrong.
● The management team worked with other organisations including local authority commissioners and social workers to support people's health and wellbeing.