Oakridge Care Homes Limited

Melbourne House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**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 10 people lived at the home.

People's experience of using this service and what we found
Leadership and governance of the service remained inadequate. The provider has not made enough improvements to demonstrate compliance with regulatory requirements. Their lack of oversight, the slow pace of improvements and the failure to learn lessons meant opportunities to keep people safe had been missed.

Aspects of the providers quality assurance systems and processes continued to be ineffective despite low occupancy at the home. Some processes and checks such as, medicines audits were not yet effectively embedded into practice.

People remained at risk of harm because some risks associated with their care and support continued not to be well managed. We found similar concerns at our last and at previous inspections. Despite our finding's people felt safe and relatives spoke positively about risk management.

Information staff needed to help them provide safe care was not always available and staff did not always follow instructions to manage risks. The management of risks associated with the environment and fire safety had improved.

Aspects of medicines management continued to require improvement and some of the improvements we found at our last inspection had not been sustained. People told us they received their medicines when they needed them.

The manager and staff understood their responsibilities to protect people from the risk of harm. Staff had been recruited safely and the staff on duty during our visit were attentive and responsive to people's needs.

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.

People liked living at Melbourne House and had opportunities to do things they enjoyed and were important to them. Feedback confirmed the homes culture was inclusive and relatives told us communication had improved since our last inspection. Staff felt supported, spoke positively about the new manager and enjoyed their jobs.

The home was clean, and visitors were welcomed. Staff worked in partnership with health professionals which supported people's health and wellbeing.

The new manager welcomed our inspection and understood their responsibility to be open and honest when things had gone wrong. The manager and care consultant were working hard to drive forward improvements and demonstrated their commitment to continually improve outcomes for people.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 04 August 2022) and there were 2 breaches of the regulations. At this inspection not enough improvement had been made and the provider was still in breach of the regulations.

Why we inspected
Due to the seriousness of the concerns identified during our last inspection we inspected the service to determine if improvements had been made and whether the conditions, we had imposed on the providers registration in 2021 had been complied with. In addition, we wanted to check the proposed enforcement action following our last inspection remained proportionate.

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.

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 that the provider needs to make improvements. Please see the safe, 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 in 2021 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.

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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 6 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, 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?

Requires Improvement

The service was not always safe.

Details are in our safe 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

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 2 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 not 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. We used all of this information to plan our inspection.

During the inspection
We spoke with 5 people who lived at Melbourne House and 4 people's relatives to gather their experiences of the care provided. We spoke with 8 members of staff including the manager, a domestic assistant, care assistants, senior care assistants, and the activities coordinator. We also spoke with the care consultant who was supporting the provider to run the service. 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 3 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment and training data. We viewed a variety of records relating to the management of the service.

Requires Improvement

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 changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our previous three 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

● People remained at risk of harm because risks associated with their care and support were not always well managed. We found similar concerns at our last and at previous inspections. That showed lessons had not been learnt.
● Some people were at risk of dehydration. To manage this risk staff monitored the amount of fluid those people drank. However, care records completed by staff did not consistently show people had drank enough to maintain their health and not enough action had been taken to address this. That meant the provider could not assure themselves the risks were well managed.
● Information staff needed to provide safe care was not always available to them. We found the same concerns in June 2022. The manager told us a person needed to drink 1000ml of fluid every day. That important information was not documented, and some staff told us they did not know the person needed to drink that amount. Opportunities to reduce the risk had also been missed because records showed the person had not always been offered enough to drink by staff.
● Staff did not always follow instructions in care records. One person had a urinary catheter. Staff told us the person did not drink enough, and they were prone to urinary tract infections (UTIs). Staff had not always recorded the amount of urine they had emptied from the person's catheter bag to monitor and manage the risk of infection.
● Risks associated with the use of emollient creams that contained flammable ingredients had not been assessed. This is important as the build-up of cream residue on bedding and clothing makes those fabrics more flammable which can result in serious or fatal injuries from fire.

Systems and processes were not sufficient to demonstrate risk was identified, assessed and mitigated. This exposed people to the 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.

● Some action was taken by the manager to improve safety following our visit. For example, information

staff needed to provide safe care was added to risk management plans and the risks associated with the use of flammable emollient creams had been assessed.
● Whilst the management of environmental risks including fire safety had improved, actions to improve other areas of service delivery, as detailed above continued to be too slow.
● Relatives told us risks associated with people's care were well managed. One relative explained the number of falls their family member had experienced had reduced. That was because staff responded quickly when their relatives falls sensor was activated.

Using medicines safely
● Aspects of medicines management continued to require improvement. Some improvements we found at our last inspection had not been sustained. Furthermore, the changes made to check medicines were being managed safely needed to be embedded into practice.
● Previously prescribed creams in use did not always have their dates of opening recorded in line with best practice guidance. This is important because creams may not be safe to use or can lose their effectiveness if they are not administered in line with manufacturer's instructions. At this inspection those concerns remained.
● Staff needed to administer a person's medicine at particular time to manage their pain. Care records lacked specific instructions for staff to follow to ensure the person always received pain free care.
● Medicine administration records had not always been signed to confirm people had received their medicines when they needed them. For example, a staff member who had administered a medicine during the morning of our visit told us they had forgot to sign the record.
● Records had not always been completed to confirm when and why medicines prescribed 'as required' had been administered. This showed staff did not always work in line with the providers medicines policy and best practice guidance.

Systems and processes were not sufficient to demonstrate people's medicines were managed and administered safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our visit action was taken to improve the safe management of medicines. For example, training was being planned to increase staff members knowledge of safe medicine practice.
● People told us they received their medicines when they needed them. One person said, "The staff give me my medication and they have not missed doing it." A relative told us, "The staff do give [Name] their medication. There have never been any issues over that."

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, laundry processes needed to be reviewed to ensure people's clothing and linen was always stored in line with best practice. The open weave baskets in use did not prevent or control the spread of infection. The manager told us they would address this.
● We were somewhat assured that the provider was using PPE effectively and safely. Staff gave differing accounts when we asked them about the providers expectations, in particular the processes they followed when they put on and removed their PPE. We brought this to the managers attention for them to address.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Government guidance was followed by the provider to ensure visits took place safely.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Systems and processes to safeguard people from the risk of abuse
● People continued to feel safe living at Melbourne House. One person smiled and put their thumb in the air when we asked them if they felt safe. A relative commented, "My relative has been here about 6 years. They are safe and happy here which is the main thing."
● The providers safeguarding systems were effective. The manager understood their responsibilities to keep people safe.
● Staff told us they had completed safeguarding training and discussions confirmed they knew how to raise safeguarding concerns if they thought someone was at risk of harm. One staff member said, "If I saw something or thought someone was unsafe, I would record it and go straight to the manager and ask them to investigate."

Staffing and recruitment
● Staff were attentive and people's requests for assistance were responded to promptly during our visit.
● People received their care from staff they knew. Some new staff had been recruited since our last inspection. That meant the numbers of agency staff who worked at the home had decreased.
● Staffing levels were determined by people's assessed health and care needs. The manager told us staffing levels would increase to ensure people's needs were met if occupancy at the home increased.
● Staff were recruited safely. Completed recruitment checks ensured staff working at the home were suitable. References had been obtained and Disclosure and Barring Service (DBS) checks had been completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

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 this key question was rated inadequate. At this inspection the rating has remained the same. 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; Continuous learning and improving care

At our previous three inspections the provider had failed to comply with regulations and assess, monitor and improve the quality and safety of the service to benefit people. 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.

● Leadership and governance remained inadequate. This is the fourth consecutive time this key question has been rated inadequate. The provider has continually failed to demonstrate compliance with the regulations related to safety and governance of the service since April 2021.
● Progress to make necessary improvements to benefit people continue to be too slow. The provider has been unable to achieve an overall rating of good since 2014. People deserve good care as a minimum.
● The providers systems for managing and mitigating risks continued to be ineffective. For example, audits of care records had not identified some information staff needed to manage risks associate with people's care was not available to them. We found this at our last inspection and risk management has been an ongoing concern to us since April 2021.
● Some governance systems were not operated effectively and opportunities to learn lessons had been missed. In June 2022 the provider had told us new medication audits would be introduced to improve medicines safety. We found those audits were not fully established or embedded into practice. In addition, the safety of medicines had deteriorated and two medicine administration recording systems were in place which was confusing for staff.
● Continued lack of provider oversight meant opportunities to keep people safe had been missed. The provider had not ensured their staff always followed risk management plans and always worked in line with their policies and best practice guidance. For example, to prevent and control the spread of infections.
● Conditions we imposed on the providers registration in 2021 to focus their improvement activities had not been fully effective. In addition, one of those conditions had not always been complied with. The manager told us an oversight had meant required information had not shared with us in October 2022.

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 person were not maintained. This was

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

● Following our inspection visit, the manager informed us of the responsive actions they had taken in response to our feedback and their plans to continuously learn and improve. For example, further information was added to people's risk management plans and staff meetings were planned to remind staff of the providers expectations.
● The management team at the home had changed. Following our last inspection, the registered manager had left the business and a new manager had been appointed in August 2022. The nominated individual who is responsible for the supervision the management team had also changed.
● The manager told us they had been working hard to implement new processes and systems in the short time they had worked at the home. They said, "There is lots to do, I am doing it and it will get done. I need more time to do it." One way they planned to make improvements was by empowering staff to take on more responsibilities in accordance with their role. For example, senior care staff liaising with health professionals more to improve outcomes for people.

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
● People continued to enjoy living at Melbourne House and spoke positively about the management team and their care and support. One person said, "Everything runs well, my care is good." A relative commented, "My wife has spoken to the new manager and said they got a good feeling about them."
● Staff felt supported and enjoyed working at Melbourne House. One staff member said, "The manager is supportive and is arranging a staff meeting for us. I am proud to work here and look after the residents."
● Feedback confirmed the home's culture was open and inclusive. One person told us their family members had joined them to celebrate their birthday. They said, "It was just wonderful. My daughter came, we had champagne." A relative described feeling 'warmly welcomed' when they visited. Another relative told us communication had improved since our last inspection.
● Quality questionnaires had been sent to people, their relatives, and visiting health professionals since our last inspection. Feedback gathered was overall, positive. Monthly newsletters sharing a variety of good news stories and upcoming events had been developed and were shared with people and relatives.
● Opportunities for people to do things they enjoyed and were important to them continued to improve since June 2022. Positive links had been established with a local place of worship and people were supported to practice their faith in line with their wishes.

Working in partnership with others
● The manager and staff demonstrated commitment to working with health and social care professionals to support people to remain healthy and well. A relative told us, "If there are any health issues about [Name], the staff contact me straight away. They chat with me and tell me what the GP has said. It's reassuring."

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
● The manager welcomed our inspection visit and understood their responsibility to be open and honest when things had gone wrong.

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 12(1)(2)(a)(b)(e) Systems and processes were not sufficient to demonstrate risks were identified, assessed and mitigated.

The enforcement action we took:

Cancellation of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1)(2)(a)(b)(c) Systems were not established or operated effectively to assess, monitor and improve the quality and safety of the service. Accurate and up to date records in respect of each service user were not maintained.

The enforcement action we took:

Cancellation of the provider's registration.