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

Summary of findings

Overall summary

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. At the time of our inspection there were 20 people living at the home.

People's experience of using this service and what we found
During our inspection visit in April 2021 we found people did not receive safe care. At this inspection we found this continued to be the case. Risks related to people's health and safety were not consistently managed. This included risks related to infection prevention and control, skin damage, falls, nutrition and management of health conditions. There was a high usage of temporary staff who did not always know about people's needs. Care records continued to lack detailed information to help staff support people safely. Medicines were not managed safely in line with best practice guidance to ensure people's healthcare needs were managed effectively.

Whilst there had been an improvement following the last inspection in relation to the cleanliness of the home, infection prevention and control practices continued not to be safe. COVID-19 checks were not completed in line with government guidance. There was no infection, prevention control policy accessible to staff.

Staff training on people's specialist needs was limited or had not been completed. People were not always supported with their nutritional needs and records lacked information to demonstrate health professional advice was always followed to support people's needs. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Governance systems, and manager and provider oversight of the service, were inadequate. Quality monitoring and audit systems were not fully implemented. The provider's policies and procedures were either not available or lacked detailed guidance to support staff. Audit checks completed lacked detailed information to be effective. The provider had failed to identify 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 (and update)
The last rating for this service was inadequate (published 18 June 2021) and there were multiple breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out a focused inspection of this service on 6 April 2021. Breaches of legal requirements were

found. The provider failed to complete an action plan after the last inspection to show what they would do and by when to improve. Following the last inspection, we continued to receive concerns in relation to staffing, people's health and safety, nutrition and management of the service. As a result, we undertook another focused inspection to review the key questions of Safe, Effective and Well Led which contain those requirements.

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

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 in key question Safe, Effective and Well led. The provider made arrangements to take immediate action to improve high risk areas we found.

The overall rating for the service has remained inadequate on the findings at this inspection.

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 continued breaches in relation to risks associated with people's care, 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. As a result, the actions agreed at our last inspection which was to place conditions on the provider's registration will continue to remain in place.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 therefore remains 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?

Inadequate

The service was not Safe.

Details are in our Safe section below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective section below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our Well Led section 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 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 three inspectors on 26 July 2021, and two inspectors on 9 August 2021 all of whom visited the home.

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, but they were not registered with the Care Quality Commission. This meant the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

This inspection was unannounced.

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 and one relative about their experience of the care provided. We spoke with 11 members of staff including the provider, manager, cleaning staff, chef, and care workers (including temporary care workers). We observed care to help us understand the experience of people who could not talk to us.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and training. We viewed a variety of records relating to the management of the service including policies and procedures that were available.

After the inspection
We continued to seek clarification from the provider to validate 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 the last inspection this key question was rated as inadequate. At this inspection this key question has now remained the same. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection 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 continued not to be safeguarded from the risk of abuse because systems and processes to keep people safe from harm were not always followed. This included risks in relation to skin damage, nutrition, moving and handling people and fire safety.
- The provider failed to identify staff were not always identifying concerns when checking people. For example, one person had developed a pressure wound as a result of their skin rubbing against the wall by their bed. A staff member told us they had noticed it, but they had not done anything about it. This resulted in a delayed medical response to address the wound. A health professional visited to assess the wound that had developed, at which point the bed was moved to prevent further skin damage.
- One person at risk of developing sore skin was left seated in the same chair for seven hours including through lunch without being repositioned as stated in their care plan. This placed the person at increased risk of skin damage. This person was to have hourly checks at night due to the risk of them falling. There were no records to show these checks took place. The manager was not able to confirm why this was. We sought confirmation of action taken to address this following our inspection.
- One person with sore skin had refused the application of creams to address this on numerous occasions. Action had not been taken in the person's best interests to prevent further skin damage and discomfort. We sought confirmation of action taken to address this following our inspection.
- At the last inspection, people's personal emergency evacuation plans (PEEP's) were inaccurate to support staff and emergency services in the event of a home evacuation. These continued to be inaccurate at this inspection. Equipment listed on PEEP's to help assist two people to move was inconsistent with what was written in care plans. This placed people at risk of harm.

In relation to areas of concern above, we sought assurances from the provider that immediate action was taken to address them to keep people safe.

Using medicines safely

- Medicines were not managed and administered safely. One person told us, "I know lots of people are

complaining they haven't had their medicines. There must be a problem."
● One person had not received their prescribed eye drops because they were still in medicine delivery boxes from the pharmacy and had not been checked and put into the medicine trolley. Staff confirmed they had been there for several days. This placed the person at risk of eye discomfort and the person expressed their anxiety around this. Action was taken by the provider following our visit to address this.
● A temporary nurse was not provided with a detailed handover to support them in medicine management. Photographs on medicine records were not recent making it difficult for the nurse to identify people when administering medicines. This prolonged the medicine round. We saw the nurse was stopped by the manager prior to administering a person's medicine because the person needed to have their medicine with yoghurt to minimise the risk of them choking. This information had not been recorded in the person's care records. Whilst this was addressed following our visit the lack of information placed the person at risk of not having their medicines administered safely.
● There continued to be a lack of detailed information about the administration of topical creams which meant it was not clear what cream was to be applied, and where, on the body. One person had been prescribed a cream four times a day "as directed". There was no detail where this was to be applied. Daily records showed an inconsistency in regard to what creams were used and where these creams were applied. During a staff handover meeting, the person was reported to have sore skin. The provider confirmed following our inspection action was taken to address cream applications and records to keep the person safe from harm.

Preventing and controlling infection
● Infection, prevention and control was not safely managed. At the time of our visit there was no Infection prevention and control policy in place with current guidance to support staff in the management of safe infection control practice. We could not be assured that government guidance was followed as practices we observed did not follow this guidance.
● BAME (black and minority ethnic) Covid-19 risk assessments had not been completed for staff. This was confirmed by the manager. This showed risks associated with staff in high risk groups were not assessed to ensure they were kept as safe as possible at work.
● Visitors and staff accessed the home without sufficient checks being made to identify, and prevent, the spread of infection in line with government guidance. On 26 July 2021, inspectors were not asked if they had completed a lateral flow test that morning. Inspectors were not asked to wash their hands. On 9 August 2021 a visiting health professional who entered the home was not asked for evidence of lateral flow test result, their temperature was not taken, and they were not asked to sign in. We observed staff did not wait the full amount of time for lateral flow test results before entering the communal areas of the home.
● Whilst cleaning of the home had improved since our previous inspection, when cleaning staff were not on duty touch point cleaning was not completed to help prevent the spread of infection. The manager confirmed this and stated this was "a work in progress".

Learning lessons when things go wrong
● Lessons had not been learned because there continued to be areas of risk not effectively managed to keep people safe from the risk of harm. Safeguarding incidents showed insufficient action taken to improve the quality of care provided.
● The lack of management oversight continued to be an area needing improvement demonstrating lessons had not been learnt. Areas needing improvement were not always identified and acted upon swiftly to ensure the service operated safely.

The above failures meant there was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● A number of staff employed by the home had left resulting in high usage of temporary staff who did not always know about people's care and support needs. Safeguarding incidents at the home brought into question the effectiveness of staff training and staff competency. Staff were not always around to support people resulting in people receiving delayed care.

● There had been an incident where staff had not identified a concern relating to a person's catheter (tube that drains urine from the bladder). This was only noted when a health professional visited. The lack of understanding around catheter checks placed the person at risk of infection.

● Staff skills and knowledge continued to be limited in respect of risk management. Some staff demonstrated gaps in their knowledge. For example, one person had swollen legs which we were told was as a result of a health condition. There was no care plan or risk assessment in place to instruct staff how to manage this although this was subsequently developed. Staff did not know about the need to encourage the person to elevate their legs. There was no instruction for them to do this in the care plan records. A temporary staff member said, "I didn't know, no one told me." A regular staff member said, "Oh, does she? (need to elevate legs), I will raise them".

● In the dining area one person said, "This is my first day here, I don't know what to do, no one helps me. I don't know what to do, they are supposed to be helping." (It was not their first day, they were living with dementia). No staff were present to support them at this time. Another person told us, "Some people have to wait a long time as there's no staff around. I hear them (people) shouting out." A staff member told us, "There is only one senior. We do find it really hard… It must be stressful for the senior too. I feel the staffing numbers should increase."

● Staff training on people's specialist needs was either limited or had not been completed. Care plans lacked detailed information about people's needs or did not contain accurate information to help staff support people safely.

● We observed staff used unsafe practices to move people. Equipment was used to move people that people had not been assessed for. Safeguarding records we had received identified that one person had sustained an injury as a result of being moved inappropriately which required medical attention.

● Recruitment checks were completed but these were not consistently thorough enough to assure the provider staff were safe to work with people. For example, records for a temporary nurse showed an expired PIN (personal registration number). This is assigned by the NMC (Nursing and Midwifery Council) and is compulsory to work as a nurse in the UK. The provider told us they had not noticed this. Whilst we established through our own checks this had been renewed, the record had not been updated and had been accepted by the provider without question.

The lack of sufficient numbers of suitably competent and skilled staff was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 inadequate. At this inspection this key question has remained the same. 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 previous 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 continued to be at risk of malnutrition. Records were not consistently maintained to demonstrate all food and dietary supplements identified for people at risk, were provided. There were unexplained gaps on food records which meant it was not clear people had eaten anything.
● One person was to have fortified foods (high calorie) and snacks each day to increase their nutritional intake. The food records did not show fortified foods and snacks were provided consistently. We observed the person was frail and their records showed they had lost weight.
● One person's dental care needs had not been followed up to ensure they could eat properly. The person was not wearing their dentures which limited the food they could eat. Staff told us the person had not been wearing them for some time and it took a long time for the person to eat. A referral was only made after this was raised during the inspection.
● There continued to be an issue in providing people with regular drinks and at their request. For example, on both days of the inspection visit, people were left waiting for drinks. At breakfast time, five people had received their breakfasts before drinks were provided. One person had finished their breakfast before they were offered a drink. During the morning two people asked inspectors if they could have a drink. We were told action would be taken to ensure the provision of drinks was managed more effectively including closer monitoring of fluid records to check this..

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

Staff support: induction, training, skills and experience
●Staff had access to some training, but people's experiences of care demonstrated this was not effectively organised to maintain staff competencies and understanding. People continued to experience failures in care relating to nutrition management, continence care, safe moving and medicine management. The staff

training matrix showed gaps in training linked to 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 could not recall dementia care training and said they didn't provide care any differently to those people living with dementia. This demonstrated their lack of knowledge. We observed staff were not always responsive to people with behaviours that challenged resulting in their, and others, behaviours escalating.
● The provider was not able to demonstrate staff induction training was linked to the Care Certificate where staff competencies are tested and demonstrated. Staff were expected to complete tasks where they had not received training. For example, the manager told us care staff were responsible for applying prescribed creams to people, but some staff had not received training in this area. The provider told us training for staff was ongoing.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were given some choices in relation to their everyday care and decisions. A relative told us, "I can't see why facilities can't be provided for people to make their own drink … It's taking their independence away."
● Care records were not accessed by all staff to enable them to understand people's needs and choices. For example, temporary staff did not consistently have access to people's electronic care records. A handover record summarised some of people's support needs but information about choices was not included. These records were also not always accurate. For example, one entry stated a person was independent with personal care, but their care records confirmed they were supported with personal care.
● People were asked what meals they wanted but we observed two people didn't understand what the meal options were, and no visual aids were used to support them to make a choice. One of these people commented to the other, "What did you choose?" They responded, "I don't know, I don't know the difference." Another person was given toast with marmalade on it. We asked the person if they liked marmalade they said, "Yes I do, it's a good job as it comes with it already on. You get what you are given here."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● While the management team had developed links with a variety of professionals, staff did not always access records where advice had been provided or recorded to ensure this was followed to maintain people's health and wellbeing.
● People were not always supported to access external health appointments in a timely way. We identified one person's need for a dental referral had been delayed and there had been delays in requesting equipment people needed to move and transfer safely.
● We had observed on more than one occasion a person was not able to sit comfortably in a chair and was in pain and discomfort when being moved. Professional advice had not been sought around this until after the manager was alerted to it by inspectors.
● Where people had refused care, or were receiving medicines covertly, this had not been identified as needing to be followed with a health professional to ensure a safe plan of care could be agreed.
● The provider continued to work 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. Audit systems, care plans and policies and procedures were being developed or updated.

Adapting service, design, decoration to meet people's needs
● There was an open staircase which was not secured and there were people living with confusion or dementia who could potentially access the stairs putting them at risk of falls.

● The communal areas of the home were spacious and easily accessible. A lift was available to assist those people with limited mobility to access rooms on upper floors.

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 and continued to be in progress at the time of our visit.
● 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 knew people had the right to refuse care and make their own decisions and there was some evidence unwise decisions were respected. However, it was not evident best interest decisions were explored where this had a negative impact on a person's health. For example, when a person refused medicines.

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 inadequate. At this inspection this key question 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our previous comprehensive inspection, the provider had failed to effectively 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 (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.

● The provider failed to ensure effective quality assurance checks were in place. For example, medicine's checks were not sufficient to identify issues needing attention to ensure medicines were safely managed. Checks of staff competency to make sure people were repositioned or moved safely were not effective to prevent injury, skin damage or pain. Infection, prevention and control procedures were not consistently checked to ensure staff practice kept people safe.
● The provider had not ensured staff had the training they needed to effectively fulfil their roles. Staff continued to have gaps in their knowledge of people which meant people did not always receive person centred care. One staff member told us they did not look at people's individual care plans as they could not read the small text. Temporary staff told us they relied on regular staff to tell them about people. We asked a regular staff member how temporary staff knew about people's needs. They told us, "They just don't know."
● The provider had not ensured people had opportunities to feedback about the service to drive improvement. People told us there were no meetings to enable them to be involved in decisions about the home and their care. People did not always experience positive care. Comments included, "It's never been this bad, I don't know the staff now. No one tells us what is going on. I just see new faces which I don't like…", and, "People do shout at each other which is wrong. People get upset and angry."
● People did not experience a positive environment. One person told us, "It could be better if there was more to do, the days are very long when there is nothing to do. Days revolve around mealtimes and they are spoilt by [person]. Staff do nothing to stop them (behaviours). They can be scary, so I keep away from them."

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 provider did not have an effective system 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, continued to be missed.
● Systems were not developed to enable lessons to be learnt when things went wrong. For example, there was no analysis of people's weight to identify any changes in approach to nutrition concerns despite it being known some people had continued to lose weight. There was no analysis of accidents and incidents in the home to identify ongoing risks and ensure any improvements needed could be addressed.
● Staff did not have access to policies and procedures to provide them with the guidance they needed to provide consistent care because the provider was updating them. This had been ongoing for several weeks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had not experienced opportunities to engage with one another and staff during any meetings or social events. One person told us, "We need more staff definitely, staff don't really have time to talk to us." The new staff don't know us. We don't go out anywhere, it would be good if we could. No, I've not been asked about that kind of thing (going out)."
● Systems to gather people's views of the service such as quality satisfaction surveys had not been developed or implemented to help identify what was important to people in how they received their care and support.

Continuous learning and improving care
● We continued to find areas needing improvement that we had identified during previous inspections of this service. There had been delays by the provider in implementing changes which had impacted on learning and improving care.
● The provider was still in the process of developing systems, policies and procedures and updating people's care plans to help identify areas needing action to improve people's experiences of care. Record keeping plays a fundamental part in providing high quality care
● During our last inspection some people used unsafe walking frames as the ferrules (rubber feet) had worn to the metal increasing their risk of falling. During this inspection we found a person's frame with worn ferrules. Whilst this was replaced during our visit, the manager confirmed audits of peoples walking frames did not take place to make sure they were safe. Lessons had not been learnt following our last inspection placing people at increased risk of falling.

There continued to be 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.

● There was a newly appointed manager in post at the time of our inspection but they were not registered with us and were being supported by the provider who was present in the home most days.

Working in partnership with others
● The management team had links with a variety of professionals to support people's needs. However, it was not always clear from records we reviewed that advice provided was followed to help people's health and wellbeing improve.
● The provider continued to work with a care home consultant and the local authority to identify where their systems had failed with the aim to improve them and the quality of their service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not sufficiently supported to ensure they were suitably trained and competent to carry out their duties effectively.