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West Melton Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
West Melton Lodge is a residential care home providing personal care for up to 32 people. Some people using the service were living with dementia. At the time of our inspection there were 17 people living at the home.

People's experience of using this service and what we found
The service has a history of breaching regulations. Shortfalls related to governance had been noted at the five previous rated inspections of the service. The service was rated inadequate in 2016 and in 2017 and rated requires improvement in 2016, 2017, 2018, 2019, and 2020. This indicated a pattern of failure on behalf of the provider to ensure improvements were sustained. This inspection highlighted similar areas of concerns.

The provider had a system in place to monitor the quality of service provided. Some concerns raised during the auditing process were identified, although some issues were not resolved. We found concerns with the way health and safety issues of the building were managed.

We were not always assured that infection control was being managed in a safe way. For example, pedal bins throughout the service were not operating properly, a toilet floor was stained and worn, deep cleaning was not always being carried out, a mattress was heavily stained, and some areas of the building were worn and not able to be cleaned effectively. Action was taken following our inspection to reduce cross infection.

Risks associated with people's care had been identified but were not always managed appropriately. For example, we found an item of moving and handling equipment which had not been serviced in line with LOLER [Lifting Operations and Lifting Equipment Regulations 1998] regulations.

On the day of our inspection we observed staff interacting with people and found there were enough staff to meet people's needs. However, staff we spoke with told us they often struggled to meet people's needs in a timely way. Staff felt this impacted on the choices available to people.

People received their medicines as prescribed however, we found areas that required improvements. For example, temperatures of the medication trolley stored in the communal lounge was not recorded. People who required medicines on an as and when required basis, had protocols in place, but these required more detail. We have made a recommendation about the storage and management of medicines.

Accidents and incidents were recorded. However, the analysis needed improvement to ensure incidents were appropriately analysed to ensure lessons were learnt.

Staff knew how to recognise and report abuse. The provider had a system in place which ensured staff were recruited safely. Pre-employment checks had been carried out prior to staff commencing employment at

the home.

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)

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 21 January 2021) and there were breaches in regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service had deteriorated to inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about infection control, staffing, training, and poor building maintenance. A decision was made for us to inspect and examine those risks.

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 found the provider to be in breach of regulation 12 and regulation 17. These were continued breaches from the last our last inspection. The provider has taken action to mitigate the risks and if this has been effective.

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 have identified breaches in relation to safe care and treatment, infection prevention and control and good governance.

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

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

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

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

Inadequate

The service was not 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.

West Melton Lodge

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
The inspection was carried out by one inspector

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

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

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and five relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, senior care workers, care workers and ancillary staff. We observed staff interacting with people who used the service, to help us understand their experience. We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

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

Preventing and controlling infection

At our last inspection the provider had failed to ensure people were protected from the risk and spread of infection. 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.

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We completed a tour of the home with the manager and found some areas which were not well maintained and unable to be cleaned effectively. For example, we saw a heavily stained mattress, pedal bins throughout the home were not operating properly, a toilet floor was stained and worn, and deep cleaning was not always being carried out.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

People were not always protected from the risk and spread of infection. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks associated with people's care had been identified but were not always managed appropriately. For example, we found a stand aid, used to assist people to mobilise, which had not been serviced in line with LOLER [Lifting Operations and Lifting Equipment Regulations 1998] regulations.
- We also identified a sensor failure to a passenger lift door, which meant the door closed even when an obstruction should have prevented it.
- Following our inspection, the provider took appropriate actions to address these concerns.

Systems and processes to safeguard people from the risk of abuse

- The provider had a system in place to safeguard people from the risk of abuse.
- The registered manager kept a record of safeguarding incidents and the outcomes.
- Staff told us they felt able to recognise if abuse was occurring and would report it straight away.

● People we spoke with told us they felt safe. One person said, "If I didn't feel safe, I wouldn't be here."

Staffing and recruitment

● The provider had a system in place to ensure staff were recruited in a safe way. Pre-employment checks were carried out prior to staff commencing in their post.

● Staff told us there were not always enough staff especially in the morning. The registered manager told us staffing had recently been increased from two to three in a morning. However, staff informed us this was not always the case. One staff said, "Not enough staff in a morning, sometimes we drop to two staff and it's just not enough as we have a lot of people who require two of us. We have three staff now but if we can't get cover and there is only two and one administers medication." Another staff said, "The workload is far too much, and we don't get a break. Staff differs sometimes two or three in a morning; one person is very often split between two roles cleaning and care. Cleaners do what they can, but they can't get to the deep cleaning."

●Relatives we spoke with gave mixed views about staffing. Most said they couldn't really comment due to restrictions in visiting during COVID-19. However, one relative said, "They seem to be a bit understaffed at the moment." Another relative said, "The staff have been very supportive since [relative] has been in the home. There seems to be enough staff when we have visited."

Using medicines safely

At our last inspection the provider had failed to ensure people received their medicines as prescribed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found the provider had improved in this area and are no longer in breach, we have made a recommendation.

We recommend the provider implements a system to monitor temperature recordings of medication storage and reviews PRN protocols.

● We checked medicines to ensure they had been administered as prescribed and found no errors.

● People who required medicine on an 'as required' basis, [often referred to as PRN], had protocols in place. However, these contained limited information and did not record how people would present if they required this medicine.

● Not all medication storage was checked to ensure these were at the recommended temperature for storing medicines.

Learning lessons when things go wrong

● The registered manager kept a record of accidents and incidents which occurred in the home. This was not always effectively analysed to ensure future incidents were kept to a minimum.

● A recent incident had occurred whilst staff were moving and handling a person. Staff involved had received moving and handling training. However, some newly appointed staff had not received moving and handling training. Therefore, lessons had not been learned from the recent incident.

Inadequate

Is the service well-led?

Our findings

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

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

Continuous learning and improving care

At our last inspection the provider had failed to ensure quality management systems in place were effective. This was a continued 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.

- Systems in place to monitor the quality and safety of the service were not robust and did not always identify and address issues.
- Governance systems had not identified shortfalls in medicine management, infection control, staffing and staff training. For example, the mattress audit dated June 2021 was completed by the registered manager, the heavily stained mattress we found had not been identified. The provider also completed a visit on 20 July 2021 and carried out a room audit for the same room. The record stated, 'Fine, no odours, clean and tidy.'
- The moving and handling equipment had been serviced in June 2021; however, one item had been missed. The registered manager had not identified this as part of the auditing process.
- The registered manager told us they had completed competency checks to ensure staff were appropriately trained. However, we spoke with staff and they said, "We had training in COVID-19 and hand hygiene training was completed and I did moving and handling on line in June 2021, but I have not had a competency assessment or any recent practical training" and "I have not done any training for ages, but we have been told we have to do more training since the inspection took place. It's been two years plus since I did moving and handling training and I have not had my competency check."

There was not an effective quality monitoring system in place and governance systems were poor. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

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

- The provider had poor oversight of the service and demonstrated a lack of awareness of some of the issues which we highlighted at this inspection.

● The provider had not ensured that enough improvement had been made to achieve a rating of good. Since 2016, the service had been rated inadequate on two occasions and requires improvement on five occasions.
● Staff we spoke with felt unable to approach the provider, some felt the registered manager was approachable but was limited to what they could do and spend to improve the service. One staff member said, "It's not run nicely." Another said, "Every expense is spared and every corner cut." Another said, "The manager does their upmost, but they are the fifth manager in three years. They do decorate out of her own money and tops up the food budget by £25 a week. We get half an hour pay docked for breaks we never have; we are lucky to get a drink."

The provider did not have oversight of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 service was not always person centred and did not always achieve good outcomes for people.
● We observed staff interacting with people and found they were caring and considerate in their approach. However, they were frustrated because they felt they did not have the time to meet people's needs in a person-centred way. One staff member said, "It's not about residents anymore because we don't have time it's all go go go." Another said, "We get people up when we can get them up, people don't really have a choice on what time they prefer to get up."
● People we spoke with were happy living at the home. One person said, "I tried another home, but I wanted to come back here, this is my home." Another said, "I enjoy it here, I'm happy and that counts for a lot in my book."
● Most relatives we spoke with were happy with the care and support their relatives received. One relative said, "My [relative] was not looking after themselves at home. Since they have been at the home their health has improved and they look better." Another said, "The home keeps in touch with us and they let us know when [relative] is not well." Another relative said, "One thing I would say needs improvement is the garden. It needs a lot of attention. We like to sit in the garden as [relative] was a keen gardener but it is not well maintained."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The home involved relatives by asking them to complete questionnaires. Results from the last survey completed in January and February 2021 showed some actions had been taken following feedback.
● We spoke with five relatives and they all told us they had not been asked to complete a questionnaire. However, they felt the registered manager was approachable.
● A staff meeting took place on 9 July 2021, where staff raised concerns regarding the cleanliness of the home. Staff felt stressed and rushed and unable to provide quality care. Since then, the provider agreed to rota three staff to work each morning. However, staff told us this was not always the case and domestic staff are often pulled off their role to provide support to care staff.

Working in partnership with others
● There was evidence to show the provider worked in partnership with others to ensure people received the right support. We saw healthcare professionals had been involved where required.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the risk and spread of infection.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure quality management systems in place were effective.

The enforcement action we took:

Warning notice