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Balliol Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to pilot a new process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection of Balliol Lodge Nursing Home. The home provides residential and nursing care for up to 32 people living with dementia or other enduring mental health needs. Accommodation is provided over three floors, with the dining room, lounges and some bedrooms on the ground floor. It has two passenger lifts and a garden to the rear of the building. The home is situated within walking distance of Bootle town centre. Twenty-one people were residing in the home at the time of our inspection.

A registered manager was in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

People living at Balliol Lodge Nursing Home were receiving care and support that was tailored to meet their individual needs. Staff ensured they were kept safe from abuse and avoidable harm. Staffing levels were sufficient to meet the needs of people living at the home.

In the main, safe systems were in place for the management of medication. However, we did find 'when required' medications were not always managed in accordance with national guidance. We recommend that the service considers arrangements for the use of 'when required' medication to ensure it is working in accordance with the NICE guidelines on managing medicines in care homes.

New staff underwent recruitment checks to ensure they were suitable to work with vulnerable adults. An induction programme was in place and staff were supported through supervision and on-going training. Staff received an annual appraisal of their performance.

We found staff were caring and treated people with dignity and respect. The majority of concerns raised by families were responded to in a timely way.

The principles of the Mental Capacity Act (2005) were not always followed for people who lacked mental capacity to make their own decisions. For example, mental capacity assessments were generic in nature and just indicated that the person could make simple decisions but not complex decisions. This meant it was not clear what types of simple decisions people could make and the types of complex decision making they needed support with. We recommend that the service considers its approach to seeking the consent of people living at the home in to ensure it is working in accordance with the principles of the Mental Capacity Act (2005).

The registered manager was new to the service and had made many positive changes. From listening to people's views and discussions with staff, we established that the current leadership within the home was strong and effective. The quality monitoring systems had been developed and introduced by the registered manager so it was too early to determine their effectiveness and impact.

Summary of findings

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. 'When required' medication was not being given in line with national good practice guidance.

People living at the home were protected from bullying, harassment, avoidable harm and potential abuse. Staff understood what abuse was and they were aware of what to do if they suspected abuse had occurred.

Risk assessments were in place for each person and there was good balance between managing risks whilst supporting people to be independent.

There were sufficient staff members on duty at all times to meet people's personal care, nursing needs and to keep people safe throughout the day and night. We found effective recruitment checks were in place to ensure staff were suitable to work with vulnerable adults.

Arrangements were in place to manage risks associated with the environment and equipment used at the home.

Is the service effective?

Requires Improvement

The service was not always effective. For example, mental capacity assessments were very general and did not make clear what decisions people lacked capacity to make. The registered manager and staff had a good understanding of the Mental Capacity Act (2005), including the Deprivation of Liberty Safeguards.

People were supported to maintain optimal health and had access to a range of healthcare professionals when they needed it. People's care records were personalised and care plans provided guidance on how their care needs should be met.

People received a balanced diet. They had sufficient to eat and drink throughout the day and night.

Arrangements were in place for staff to receive regular training, including refresher training so that that people were supported by staff who had the knowledge and skills to carry out their role.

Is the service caring?

Good

The service was caring. We observed that staff were caring and treated people with dignity and respect. This observation was supported by the people and families we spoke with. Staff had a good knowledge of the preferences and preferred routines of the people they supported.

We determined through discussions with people, families and by looking at care records that people and/or their families were involved with making decisions about their care and support.

Summary of findings

Is the service responsive?

Good

The service was responsive. People living at the home said the staff respected and supported what was important to them, including their preferred choices. People's care was reviewed on a monthly basis to monitor if there were any changes to their care and support needs.

A range of methods were in place for people to express their views about the service, including a 'resident/relative' meetings and a questionnaire to contribute to a satisfaction survey.

The people and families we spoke with were aware of how to make a complaint or raise a concern. We found that concerns had been responded to in a timely way.

Is the service well-led?

Good

The manager had been in post for four months and was registered as a manager with CQC on 30 June 2014.

Families and staff were positive about the new registered manager and told us there was more structure and consistency to the service. They were pleased that improvements were being made to the service, in particular improvements to the building and environment.

Meetings and a feedback process were in place to ensure people living at the home, their families and staff had the opportunity to express their views about the development of the service.

The quality monitoring systems introduced by the registered manager had not been in place long enough to provide sufficient assurance of their effectiveness.

Balliol Lodge Nursing Home

Detailed findings

Background to this inspection

We visited Balliol Lodge Nursing Home on 22 July 2014 and spent time with six people and invited them to share with us their views and experience of living at the home. We spoke with two family members who were visiting their relative at the time of the inspection. We also spoke with a registered nurse, five members of the care staff team, the registered manager, the administrator and the provider (owner).

We observed care and support being delivered in communal areas. We had a look around the building, including a visit to the kitchen and we looked at some people's bedrooms. In addition, the inspection involved reviewing a wide range of records, including four people's care records, three staff recruitment files and records to demonstrate how the home was being managed.

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

Before our inspection we reviewed the information we held about the home including the provider information return.

We contacted the commissioners of the service to obtain their views of the service. We also invited health and social care professionals who visited the home on a regular basis to share their views on the quality of care provided.

This was the fourth inspection of the home since September 2013 when we had found major concerns about the standards of care in the home and breaches of regulations. We took enforcement action following the inspection in September 2013 and made it a condition that the provider would not admit any more people to the home. This condition was still in place during this inspection.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint and the MCA under the 'Effective' section.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with said they felt safe in the way staff supported them. They told us they did not have any concerns about staff treating them unkindly. A person said, "I feel comfortable with the staff. They're okay." Throughout the inspection we observed staff supporting people in a safe and caring way.

People also told us there was enough experienced staff on duty to ensure they received safe care. A person said, "I think there is enough staff to look after people. The staff have tests every so often to make sure they know things." Another person told us, "I've never needed to press the bell. The staff are always around. Up to now they have had enough staff. The staff know what they are doing."

Families we spent time with said their relatives were supported in a safe way. A family member said to us, "The staff make the home safe. I think my [relative] is handled and moved around well. She has been here eight years." Another family told us, "There's always two carers using the hoist with my relative. I see two staff walking with a resident; one at the back and one at the side." Furthermore, a family member said, "Residents are never left on their own in the lounges." Overall, families felt the staffing levels were sufficient to provide safe care.

Staff told us they were satisfied with the staffing levels. Both the registered manager and staff confirmed that each day there was a registered nurse and five care staff on duty, reducing to four care staff in the afternoon. A registered nurse and three care staff were on night duty. We observed during our visit that there were sufficient staff on duty and people's needs were met in a timely way. The care records we looked at showed that an assessment was carried out to determine the level of support each person needed from staff (referred to as a dependency needs assessment). The assessments were reviewed on a monthly basis which showed staff were monitoring for any changes in dependency levels.

We spoke with four staff about their understanding of how to maintain the safety of each person. They demonstrated a good knowledge of each person's individual needs and risks, and their responsibilities with maintaining the safety of people living at the home. In addition, they had a good understanding of what adult abuse was and were able to clearly describe how they would respond if they identified potential abuse. The staff we spoke with confirmed they were up-to-date with their required training in the safeguarding of vulnerable adults.

The four care records we looked at included a range of assessments and care plans for people with risks associated with their health and welfare needs. We could see from the records that family members were informed if their relative experienced an event which had caused harm or put the person at risk. When a risk was identified and, if appropriate, staff referred people to a relevant external healthcare professional.

A family member told us the medication was "given out by a qualified nurse" and that the "medication trolley was locked up." We observed the registered nurse administering the medication and this was undertaken in line with good practice procedures. We observed that a person was prescribed tablets for pain relief on a 'when required' basis. A plan was in place directing when staff could give this but it had not been reviewed since it was put in place in August 2013. We observed that the tablets had been given consistently each morning which meant it had become a routine medication rather than a 'when required' medication.

We looked at the personnel files for recently recruited members of staff. Effective recruitment processes were in place, including the required checks to ensure the staff were suitable to work with vulnerable adults. We observed that action had not been taken as part of the recruitment process when a member of staff had declared a criminal offence. We discussed this with the administrator who said a risk assessment had been undertaken but that the risk assessment recording tool, usually used for such matters, had not been used on this occasion.

Interview notes, an induction checklist and qualifications were retained on the personnel files. Checks were also made of the status of the professional registration of the nurses. A recently recruited member of staff that we spoke with confirmed the recruitment process had been thorough.

Families told us they had previously raised concerns about the state of the building. They were pleased with the improvements the provider had been made. A family member said, "They've had new carpets and decorated in the last 12 months." Staff acknowledged that

Requires Improvement

Is the service safe?

improvements had been made to the building and equipment but felt further work needed to be done. Although one of the two passenger lifts was not working and some showers and baths could not be used. We discussed this with the provider and registered manager. The registered manager confirmed that all the showers had been checked and were working but the showers on the upper floor had low water pressure. The provider was looking into how this could be improved. Staff were concerned the bath seats might not be safe. The registered manager confirmed the baths had been checked by an external company on 18 June 2014 but said she would request a further check. The registered manager also confirmed that the passenger lift would be fixed by the end of August 2014.

We recommend that the service considers arrangements for the use of 'when required' medication to ensure it is working in accordance with NICE guidelines on managing medicines in care homes.

Requires Improvement

Is the service effective?

Our findings

Families we spoke with were pleased with how the staff supported their relative to maintain optimal health. A family member said, "They [staff] are extremely vigilant about health needs. They do involve me in decisions about [relative] care. The staff ring me and they make appointments if [relative] needs their eyes testing." Another family member told us, "I can ask staff to get a doctor if I think [relative] needs one. Staff tell us if [relative] is ill."

People living at the home that we spoke with had some awareness of the medication they were taking. They told us they received their medication on time and the registered nurse explained what the medicines were for. A person said to us, "They [staff] have told me what my medicines are. I'm on regular medicines. Another person said, "I'm on drops for my eyes and one pink tablet but I don't know what it is for. Furthermore, a person said, "I'm on paracetamol for pain and injections, which the nurse in the office gives me for mental health problems."

We looked at the care records for four people living at the home and could see that detailed records were maintained of consultations with healthcare professionals, such as the GP, district nurse, speech and language therapist and dietician. People were referred to specialists if there were concerns about their health. For example, we observed from the care records that a person was referred to a speech and language therapist (SALT) as there were concerns about how they swallowed food and drink. Staff were working in accordance with the care plan produced by the SALT.

We observed that the care plans associated with people's physical health were more detailed than the plans related to mental health and behavioural needs. The registered manager confirmed that all the nurses employed were general nurses. This was a matter the registered manager was looking into in terms of on-going mental health provision and skill mix within the staff team. In order to develop the nurse's skill and knowledge, the registered manager had arranged for the local community mental health team to provide training in September 2014 regarding the management of behaviour that challenges.

The registered manager understood the Mental Capacity Act (2005) and had provided in-house training for registered nurses about the Act. The Mental Capacity Act (2005) is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. The care staff we spoke with were clear about the principles and their responsibilities in accordance with people's rights to make their own decisions. They told us they would not make a person do something they did not wish to do. They said if a person refused necessary care then they would try and explain why the care was necessary or leave the person for a short while and try to encourage them at a later time.

Mental capacity assessments were contained in the care records we looked at. They were generic in nature and confirmed that the person could make simple decisions but not complex decisions. This meant it was not clear what types of simple decisions people could make and the types of complex decision making they needed support with.

Some of the people living at the home smoked. We looked at the care records for one person who smoked. Although there was no risk assessment or care plan in the care record, staff explained how the person was supported to smoke safely by retaining and regulating the amount of cigarettes the person had throughout the day. The person's mental capacity assessment confirmed they had capacity and they told us they were satisfied with this arrangement. The person said to us, "They [staff] limit my cigarettes. This is because I smoke too much if left to do it myself." This showed that staff had considered the person's rights and had balanced this with the need to protect the person's safety.

Nobody living at the home was subject to a Deprivation of Liberty Safeguarding (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The registered manager was in the process of reviewing whether some people needed to be considered for a DoLS assessment and planned to discuss this with the local DoLS coordinator.

The care records informed us that a person who lacked capacity had bedrails in place and another person who also lacked capacity used a wheelchair strap. Although both these items of safety equipment are used to keep people safe, they can be considered a form of restraint or restriction under the Mental Capacity Act (2005). Where a person lacks capacity to consent to their use, then the

Requires Improvement

Is the service effective?

guidelines of the Mental Capacity Act should be followed. This means the equipment can be used if it is deemed to be in the person's best interests. Risk assessments undertaken by a registered nurse were in place that clearly indicated the equipment was used for safety purposes rather than as a form of restraint. These assessments were reviewed each month. Good practice guidance suggests that making such best interest decisions should involve a family member or a representative for the person. It was not clear from the care records whether this level of involvement had taken place as part of the decision making process.

The staff we spoke with confirmed they were up-to-date with their mandatory (required) training. We looked at the training monitoring record and noted there were some gaps. However, the administrator advised us that any gaps would be addressed during the second round of mandatory training (mandatory training was arranged to take place twice a year). The registered manager told us they had provided sessional training for the registered nurses, including training in the Mental Capacity Act (2005), catheterisation, medication and care planning. Staff informed us they received regular one-to-one supervision and an annual appraisal. The personnel records we looked at confirmed this.

We asked people their views of the meals. One person said, "I get enough food and drink. I like fresh food. We get fruit. I can choose my food. If I don't want something they give me something else. I can choose from an alternative. They do weigh us." Another person told us, "I have toast and tea for breakfast. I like my toast well done and almost black. Staff do it like this for me. My favourite is a good roast dinner. We have two roast dinners a week. They give me a choice of food. I'm weighed once a month."

Families we spoke with were satisfied with meals. A family member told us, "My relative is not an eater. The staff jump through hoops to get her to eat and drink. They are very good at keeping her hydrated. If she has not eaten much they give her milk and fortified drinks." Another family member said, "They do make fresh pies like cheese and onion or steak. There's always a selection of things. She is a slow eater and it takes patience. We know she is well when she eats."

We observed the lunchtime meal. This was coordinated in two sittings to ensure people had sufficient support with their meal. People who needed assistance with eating and drinking were supported by staff. Staff supported people with their meal in a timely way.

The care records informed us that regularly reviewed risk assessments and care plans were in place for people with special nutritional and dietary needs. We also noted that external health care professionals were involved in the development of some people's nutritional plans. People had their weight checked each month to monitor for any fluctuation.

We observed from a monthly care plan review that a person's care in relation to their dietary intake had changed but the care plan had not been revised to reflect this. We highlighted this to the registered nurse who said it was an oversight and immediately revised the care plan.

We recommend that the service considers its approach to seeking the consent of people living at the home to ensure it is working in accordance with the principles of the Mental Capacity Act (2005).

Good

Is the service caring?

Our findings

We asked people if they were cared for with kindness and respect. The people we spoke with were satisfied with the way staff supported them and said the staff team were caring. A person told us, "I'm comfortable with the staff. I've been here since 1992 and [a relative of theirs] was here before that. The staff are pleasant enough. I prefer to be on my own in my room. It suits me. People are treated very well here."

The families we spoke with were content with how the staff supported their relatives. They said the manager communicated well about any changes to their relative's needs. A family member told us, "My relative seems settled here. I'd like her to move nearer to me but she won't move. She is happy here. I've never witnessed any staff not being kind, compassionate or caring. They are excellent. There is one carer who seems to be the designated carer. She always seems knowledgeable about [relative]." Another family member said, "Staff are very kind. They treat [relative] like I do myself. I visit anytime I want. The staff listen when I tell them things."

We observed staff supporting people throughout the day. Staff supported people in a dignified and respectful way. The majority of staff interacted in a warm and engaging way with people, particularly whilst supporting people with eating their meal. They were responsive in a timely way to requests from people. A few altercations occurred between people living at the home throughout the day and staff diffused these situations promptly in a calm and dignified way, thus avoiding the situation escalating further.

We found from our conversations with staff that they had a good knowledge of the people living at the home. They knew people's background histories, preferred routines and their likes/dislikes. However, the care records we looked at did not reflect this level of detail about people. This meant new or temporary staff would not have direct access to this information about people. Staff told us this information about people had previously been in the files but had been taken out. They were unsure why this had happened. The registered manager explained that because of previous concerns with the care records, the documentation had been revised and information about people's lives and preferences had been removed and stored away. The registered manager said they would ensure this information was returned to the care records.

Records about people living at home were located in the nurse's office. The office was locked when it was unattended which meant personal confidential information about people was stored securely. This showed that information about them was treated confidentially.

Good

Is the service responsive?

Our findings

The people living at the home that we spoke with said staff respected their preferences and preferred routines. For example, a person said, "I dress myself and choose my own clothes. I get up about 6.30 am and have tea and toast. Then I come down for breakfast at 9.30 am." Another person told us, "I don't do activities but I like to watch. I like to do sing-alongs with staff. They [staff] let me be independent when I want."

Equally, families were satisfied that the staff responded appropriately to what was important to their relative and the family. A family member said, "Staff have brought my relative to the house to visit me. She was taken to see her son's grave by the activity coordinator. She has been about three times this year. On one occasion she wouldn't go and the activity coordinator had to take the flowers without her." Another family member said, "My relative can't do anything for herself. But she likes watching any activity. They took her for a pub lunch recently."

The activity coordinator was not available on the day of our inspection. Staff told us there was not a structure in place for regular activities as activities were organised depending on how people felt each day. From our discussions with staff it was clear that trips out took place. Some staff felt people, particularly people reluctant to engage, would benefit from more encouragement to join in with activities.

We found that the assessments and care plans we looked at were reviewed each month by the registered nurses.

Records also demonstrated that staff communicated with people's families about changing care needs. Care plans were signed by the person or a family member. A family member said, "I've seen a care plan recently saying what [relative] needs and who her main carer is. I think my sister has signed it." Another family member told us, "I've not seen a care plan for a long time. I have mentioned this to the new manager and she has promised me as soon as it is updated, she will give me a copy." Records also demonstrated that staff communicated with people's families about changing care needs.

Families knew how to complain and had made complaints. We observed that the majority of complaints had been responded to within a reasonable time frame and to the satisfaction of the complainant. However, a family member who was visiting their relative at the time of the inspection told us they complained directly by email to the provider about the television that had been broken for over a month and was replaced with a small 12 inch television. The family member asked for a "proper sized" television. The provider had not responded to the complaint and the family felt their complaint was ignored. We discussed the matter with the provider and registered manager. The provider said they had no recall of receiving this email of complaint. The registered manager confirmed they had contacted the family once they became aware of the family's concerns. We received confirmation from the registered manager two days after the inspection that a more appropriate sized television had been purchased.

Good

Is the service well-led?

Our findings

The home had a manager who had been in post for four months. The manager was registered with CQC on 30 June 2014. The home was registered to accommodate 32 people. Twenty one people were living there the time of this inspection. This was because we took enforcement action following the inspection in September 2013 and made it a condition that the provider would not admit any more people to the home. This condition was still in place during this inspection.

We asked families who were visiting the home on the day of the inspection their views about how the home was managed. Families highlighted that the new manager was having a positive impact on the service. A family member said, "The home was not well led in the past. Promises were made and broken. The new manager is very approachable. She seems to be trying hard to improve things. There were a lot of issues which she is improving." Another family member told us, "My relative has been here eight years. Things are improving. The building is slowly being improved. They've had problems with managers. There's been a few come and go. I don't know why. They come, say they are going to change this and that and then they leave. Hopefully the new manager will stay."

A family member told us there had been two meetings at the home (referred to as 'resident/relative meetings') since the registered manager started working at the home. The last meeting was held on 30 June 2014. We noted from the minutes that the outcome of recent CQC inspections was discussed. Feedback questionnaires were located in the entrance hall and also given out at meetings. We observed that a small number had been completed but it was an insufficient number for an effective analysis. A newsletter for the home had started and copies of these were located in the entrance hall.

We observed that Information about how to make a complaint was displayed on the notice board in the hall. However, it was out-of-date and made reference to the previous regulatory body. It was last reviewed in 2009. In addition, the records about how complaints were being monitored and managed were not easy to follow. We highlighted both these issues to the registered manager at the time of the inspection.

We asked staff their views about the leadership and management of the service. There was a consistent view expressed that frequent changes of manager had left staff feeling despondent and uncertain. We heard from a member of staff that there had been seven managers in less than four years. Another member of staff told us, "Managers come, change the routine and then leave. It affects staff because it leaves them unsure of any routine. The manager has been here a few months. I hope she can stay and that we have stability." Staff told us the new registered manager had an open and positive leadership style. They said she was both organised and approachable.

The staff we spoke with told us they did not think the main approach to training was the most effective way to learn. They were referring to the mandatory training undertaken by watching a DVD and then completing a test. They said it did not provide an opportunity for a discussion or to check out issues they were unsure of. We asked if they had raised this and a member of staff showed us their appraisal (with a previous manager) and their views of the training had been recorded. Some staff said they had not mentioned their views of the training at staff meetings because they did not think they would be listened to. Staff said they had previously raised general concerns in staff meetings and no changes had been made. They felt the new registered manager was more open and was starting to follow-up on concerns raised. The registered manager confirmed the majority of training was via DVD but was unaware staff had concerns about its effectiveness.

Regular staff meetings took place at the home. We looked at the meeting minutes for the last three months and noted that matters such as the environment, feedback on CQC inspections and care issues were discussed. The minutes demonstrated that open and constructive dialogue took place at the meetings.

A process was in place for conducting a staff survey. Out of a team of 60 staff only five questionnaires had been returned. This was an insufficient number to provide a realistic analysis. No comments were recorded by staff. Some of the staff we spoke with told us they were reluctant to complete the questionnaire as they did not want to be identified. The registered manager confirmed that staff had been asked not to put their names to the questionnaires so staff would be more open. The manager said they would consider other ways to get a better return from staff surveys. The staff we spoke with were aware of what

Good

Is the service well-led?

whistle blowing meant and said they would have no hesitation in whistle blowing if they were concerned about something. They said they would go outside of the organisation if necessary, to CQC or social services.

A schedule for conducting checks and audits was in place. We looked at the medication audit and monthly care file audit. We could see the registered manager was identifying issues and acting on them. Incidents were monitored and analysed each month. It was clear that action was taken where appropriate. For example, a person was referred for a mental health review following a series of incidents involving behaviour that challenged others. Also, the home service was subject to an external quality assurance audit in April 2014. This was commissioned by the provider. Overall, the feedback from the audit was positive and the registered manager was able to demonstrate that some of the recommendations had been actioned. This showed the registered manager had measures in place to monitor the quality of the service provision and take action if deficits were identified.