Care Quality Commission

Blackbrook House Care Limited

Blackbrook House Care Home

Inspection report

31 Blackbrook House Drive
Fareham
Hampshire
PO14 1NX

Date of inspection visit:
05 January 2017

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10 February 2017

Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 5 January 2017 and was unannounced.

Blackbrook House Care Home provides care and accommodation for up to 28 people and there were 26 people living at the home when we inspected. These people were all aged over 65 years and had needs associated with old age and frailty.

All bedrooms were single although there was one room which could accommodate two people. Each bedroom had an en suite toilet facility. There was a communal lounge and dining areas which people used. A passenger lift was provided so people could access the first and second floors. The service was decorated and furnished to a high standard, which promoted the comfort and dignity of people living there.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service used an electronic system for recording medicines administered to people. These records did not always reflect the medicines people were prescribed which meant there was a risk people may not receive the correct medicine.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures were adequate and ensured only suitable staff were employed.
Staff were trained and supervised so they provided effective care to people.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty

Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to their care and treatment was assessed and applications made to the local authority where people's liberty needed to be restricted for their own safety.

There was a choice of food and people were generally complimentary about the meals. The food was wholesome and nutritious. People were consulted about the food and meal choices.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular checks such as dental and eyesight checks.

Staff were observed to treat people with kindness and dignity. People were able to exercise choice in how they spent their time. Staff took time to consult with people before providing care and showed they cared about the people in the home.

People said they were consulted about their care and care plans were individualised to reflect people's choices and preferences. Each person's needs were assessed and this included obtaining a background history of people. Care plans showed how people's needs were to be met and how staff should support people.

Activities were provided for people who said they were satisfied with the activities.

The complaints procedure was available and displayed in the entrance hall. People said they had opportunities to express their views or concerns. There was a record to show complaints were looked into and any actions taken as a result of the complaint.

Staff demonstrated values of treating people with dignity, respect and as individuals. People's views about the quality of the service were sought. Staff views were also sought and staff were able to contribute to decision making in the home. The culture of the service was focused on meeting peoples' needs and preferences. People and their relatives said they felt able to approach the management of the service who they had confidence in.

A number of audits and checks were used to check on the effectiveness, safety and quality of the service.

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.

Procedures for the administration of medicines were not fully safe.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff were trained and supervised so they could provide effective care to people.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice.

People were supported to have a balanced and nutritious diet. Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took time to speak, listen and respond to .

People received support and care which reflected their needs and choices.

People were consulted about their care and their privacy was promoted by staff.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and reviewed. Care plans were individualised and reflected people's preferences.

A range of activities were provided to people.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?

Good

The service was well-led.

The provider sought the views of people, staff, and, stakeholder professionals regarding the quality of the service and to check if improvements needed to be made.

Staff demonstrated a commitment to treating people with dignity and as individuals.

There were a number of systems for checking and auditing the safety and quality of the service.

Care Quality Commission

Blackbrook House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 5 January 2017 and was unannounced.

The inspection team consisted of an inspector and an Expert by Experience, who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with 10 people and two relatives of people who lived at the home. We spoke with five staff, the assistant manager, the registered manager and the provider.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for four people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints.

This service was last inspected on 14 May 2013 when no concerns were identified.

Requires Improvement

Our findings

We looked at the service's procedures regarding the safe administration and recording of medicines. The system of recording people's' prescribed medicines and the medicines administration records (MARs) provided by the pharmacist supplier were not always accurate. This was an electronic system whereby the staff used an internet portal to access MARs. We found one instance of the MAR showing someone should have a medicine three times a day when the prescription showed it should be given twice a day. Staff who administered medicines were aware of this and were following the correct prescription. The MARs were an interactive IT system whereby the records were stored on the pharmacy supplier's IT system, which the staff logged onto to access the records. The registered manager and assistant manager stated connection to the MARs was not reliable and that a backup of printed MARs was kept. We identified errors in the administration of a course of antibiotics for one person. According to the interactive MARs these had not been administered as prescribed and there was a three day gap where it was not given. The registered manager and assistant manager said this was due to the problems with the supplying pharmacist's MARs when connection to the pharmacist's MARs via an IT portal had failed. The registered manager and assistant manager said unreliability in connection to the MARs via the internet meant the antibiotic did not appear on the MARs so staff had not administered it. Therefore the person did not receive their antibiotics on successive days as prescribed, which would reduce its effectiveness. This had not been picked up and acted on by the management. We looked at a sample of other MARs which showed staff had signed a record to show medicines were administered as prescribed. Stocks of other medicines also indicated medicines were administered and people said they were satisfied with the medicines procedures. Following the inspection the registered manager said a decision was made to abandon the supplying pharmacy system and to revert to paper records.

We looked at the procedures for the storage and administration of controlled medicines, which was in accordance with pharmaceutical guidelines. However, we advised the registered manager to seek advice as the controlled drug register was not 'bound' but consisted of numbered pages held in a ring binder where pages could be removed.

Whilst there were errors in the systems for administering and recording medicines they had limited negative impact on people. The provider took immediate action to correct the errors in the MARs supplied by the pharmacist but we judged the medication systems used at the service require improvement.

People told us they felt safe at the home and were safely cared for. For example, one person said, "Yes, you haven't got to worry about anything." Relatives also said they considered the service to be a safe place for

people.

Staff were trained in procedures for reporting any suspected abuse or concerns. Staff said they would report any concerns to their line manager and knew the procedures for contacting the local authority safeguarding team. The service had policies and procedures regarding the safeguarding of adults, including a copy of the local authority safeguarding procedures.

Risks to people were assessed and recorded. There were corresponding care plans so staff had guidance on how to support people to reduce the risk of injury or harm. These included the risks of falls, the risk of pressure areas developing and risks when moving people. Risk assessments and care plans gave staff clear guidance on how to support people to mobilise safely. We observed staff supporting people to mobilise safely, which included explaining to people the most appropriate and safe way to get up. Care plans, including risk assessments, were reviewed on a regular basis so any changes in people's needs regarding risks could be identified.

People gave us mixed views regarding the staffing levels. For example one person said there were enough staff. Two other people said there were generally enough staff, but there were occasions when staff were too busy in the mornings which had led to some delays in staff supporting them. People said staff responded promptly when they asked for assistance by using the call point in their rooms. For example, one person said, "I use my buzzer at night and usually staff are very good and come quickly." Another person said, "If I ring the bell when I'm in bed they come immediately, any time of the night and I tell them what I want."

A dependency tool was not used by the provider to calculate the staffing levels but consideration was made of how many staff were needed to care for people at the time they were admitted. At the time of the inspection, four care staff were on duty from 8am to 2pm each day plus the registered manager and the assistant manager. From 2pm to 8pm three care staff were on duty. Additional staff were provided for cooking, cleaning and activities provision. Staffing was organised on a staff roster which showed staffing levels were planned for at these levels. Night time staff consisted of two staff on 'waking' duty. We observed there were enough staff to support people safely; this included the lunch time period when people were brought to the dining room and were supported to eat. Staff said they considered there were enough staff on duty. One staff member felt there was a need for more staff at night time as two staff may be needed to help one person to use the toilet, which effectively left no other staff available to help anyone else. This staff member said this had been discussed at a staff meeting and that as a result of this an additional staff member was being considered. Following the inspection the registered manager informed us that an additional staff member was working a 'twilight' shift from 6pm to 10pm each day. The registered manager also stated that one of the staff on the morning shift would be working from 7am instead of 8am to provide support during the busy mornings.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There was a record of staff being interviewed to assess their suitability for the post. The service used agency care staff on an occasional basis. The service did not check with the employment agency that the required checks were carried out for these staff but trusted the agency to do this. Guidance from the Commission recommends the service has a system to ensure the agency has made the required checks on agency care staff. Following the inspection the registered manager confirmed information about the recruitment checks on agency staff was obtained.

Checks were made by suitably qualified persons of equipment such as the passenger lift, hoists, fire safety equipment and alarms and electrical appliances. The risks of Legionnaire's disease was checked by a

suitably qualified contractor. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises. Temperature controls were in place to prevent any possible scalding to people from hot water.

Good

Our findings

People and their relatives said they considered the staff and management of the service had the right skills to provide a good standard of care. For example, a relative said care staff provided the right care and used the right equipment as well as liaising with medical services when needed. One person said, "It's first class. High standard of care and it's loving care." People said they were consulted about their care.

People gave us mixed views regarding the food. Most people were complimentary about the food making comments such as, "The food is very, very good. I've never heard any complaints about the food. There is quite a good choice." One person commented that the portion sizes were too large to the extent this discouraged them to eat.

Staff told us they had access to a range of training courses such as in the moving and handling of people, first aid, the Mental Capacity Act 2005 as well as nationally recognised training in care such as the National Vocational Qualification (NVQ) in care and the Diploma in Health and Social Care. The provider confirmed 11 of the 14 staff were either trained to NVQ level 2 or 3 or were studying to obtain these qualifications. The registered manager, assistant manager and senior care staff had attained or were studying a level five qualification in care and management. The registered manager had completed the Registered Manager's Award (RMA). These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff said the training was of a good standard and equipped them for their role and that training was regularly updated.

We looked at the training records for staff on duty. Staff completed training courses considered mandatory to their role such as infection control, diet and nutrition for those living with dementia, fire safety, first aid, pressure area care, dementia care and behaviour.

Staff told us they received regular supervision form their line manager. Staff said this consisted of one to one discussions as well as appraisals of their work by observation by their manager of their work with people. Staff said they felt they could approach the registered manager and provider with any issue which was listened to and any advice needed was given in a way which made them feel valued. Records were maintained of staff supervision and appraisals and showed this was taking place on a regular basis. There were records to show staff competency to safely administer and handle medicines was assessed including observation of staff. Staff aid they received an induction which was sufficient to prepare them for their job. Records of staff induction were maintained.

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. The application procedures for this in care homes and hospitals are 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 were being met.
The service had policies and procedures regarding the Mental Capacity Act 2005 and the associated Code of Practice. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The staff used an assessment tool for determining if people had capacity to consent to their care and treatment. At the time of the inspection one application for a DoLS authorisation had been made.

People had a choice of food and said they were asked in advance what they would like to eat for the meals ahead. We observed staff were attentive to people at lunch time to ensure their nutritional needs and food preferences were met. Where people were not eating, staff asked people if they would like something else. Where people asked for a different meal staff responded by offering a choice of meals. People's nutritional needs were assessed regarding any risks of malnutrition and each person's weight was monitored. Referrals were made to specialist health services where people were at risk of malnutrition or had difficulties swallowing. Advice from these specialists was recorded in the relevant care plans so staff had guidance on how to support people. A drinks trolley of tea, coffee or biscuits was brought round to people in the morning and in the afternoon to ensure people had enough to eat and drink. People had soft drinks in their rooms.

People said they were supported to attend appointments with their dentist and GP. Records showed people had access to medical services such as community nurses and their GP and that referrals were made when people developed medical needs. Relatives told us the staff were prompt in contacting health services when this was needed.

The environment was decorated and furnished to a high standard. Bedrooms were clean, comfortable and showed attention had been given to providing an environment which promoted the dignity of people. Lifts and stair lifts enabled people with mobility needs to access all levels of the service. Corridors were wide which allowed people to move about freely if they used any mobility equipment. There were areas where people could meet and chat. People commented on how much they liked the environment.

Good

Our findings

People and their relatives spoke highly of the caring approach of the care staff. For example, one relative said, "I genuinely believe the staff care...with love." Comments from people about the staff included the following, "They are very good. Very caring. Very patient," and, "They are always very sociable and helpful. I get on very well with them."

Staff were observed to talk to people politely and respectfully. We observed the lunch time meal. Staff asked people how they wanted to be helped, if they wanted any more food and if they wanted something different to eat. People said they were supported to be independent and said they could make choices in how they spent their time and in what they ate. For example people made the following comments, "I get up very early, I always have done. I got up at 5.30 this morning, that's my choice," and, "I get up a bit early or late, no one queries it." Details about people's preferences were included in the care plans so staff had an awareness of people's routines and lifestyle.

Each person's care plan was personalised to reflect how people's needs were to be met. These included details about how to identify and manage people's behaviour and mood. For example, one person's care plan highlighted how a 'soft and gentle approach' was needed in specific situations and another care plan gave details about how to identify and deal with a person's low mood. We observed staff reassured people who showed signs of distress or discomfort as well as checking why the person was upset.

People said they were consulted about their care and were asked how they wanted to be supported. Care plans included a document called, 'This Is Me,' which gave details of what was important to the person as well as details about their lifestyle and hobbies. The care plans and reviews included space for people's comments to be included and their signature to acknowledge their agreement to the contents of the care plans.

People said their privacy was respected by the staff who knocked on bedroom doors before entering. The registered manager said people could have a key to their bedroom door lock if they wished and that several people made use of this facility.

The service had policies and procedures regarding the importance of treating people with dignity and promoting privacy. Staff demonstrated they had a value base of treating people with respect and in the same way as they would treat a member of their own family. Staff referred to this as the 'mum test' and said they considered the service promoted this. Staff commented on the compassionate nature of the provider

and how staff always acted sensitively when people were not happy.

Good

Our findings

People said they were consulted about how they wanted to be helped and that staff responded to their requests for assistance. Relatives said the staff were responsive in meeting people's needs. Comments were made by relatives such as the following, "It's lovely here and it is lovely for mum. They do everything they possibly can." Another relative also told us the standard of care was very good.

People said their views were sought, listened to and acted on. This included the provision of food and residents' meetings where people said they could put forward their views.

People's needs were assessed and reviewed, including an assessment before people were admitted to the home, so the provider could ascertain whether the person's needs could be met. These included dietary needs, mental health, continence care and moving and handling needs. People's preferences were included in how they wished to be supported. Care plans gave staff guidance on how people should be supported, such as supporting people with personal care and mobility needs.

There was a range of activities provided for people which they said they enjoyed. These included entertainment from visiting musicians and singers. People said staff supported them to access community facilities such as the local shops. One person said they enjoyed the activities but also said they could be increased. The service employed an activities coordinator for three afternoons a week. Records of activities provided were recorded and people were supplied with a monthly programme of activities. The records showed a range of activities for people including shopping, trips out in a classic car and a walk. We observed people taking part in knitting and chatting in one of the lounges and the provider taking someone out. Entertainers also visited the home and provided music sessions which people said they enjoyed.

People and their relatives said they felt able to raise any concerns with the staff, registered manager or provider. For example, one relative told us, "I don't have any negative comments, everyone is amazing and approachable."

The complaints procedure was displayed in the home. The registered manager told us three complaints had been made in the last three years. A record was kept of these as well as details of how each complaint was looked into and the outcome.

Good

Our findings

People said they had opportunities to give feedback on the service they received by completing satisfaction surveys questionnaires. People also said they were able to air their views and discuss issues, such as the meals and activities at the residents' meetings. The surveys were distributed twice a year and asked people and their relatives about a range of aspects of the service including whether people were treated with dignity and respect, if their care needs were met and the environment. A sample of these completed questionnaires showed people and their relatives were satisfied with the service provided. Surveys were also distributed to health and social care professionals to ask them their views on the service.

Residents' meetings were held every two months and showed any feedback was acted on such as installing a new path in the garden and requests for changes to the menu plan. One person commented, "I said to the owner, 'no wonder no one goes outside, the paths are rough', and he put a concrete path down, now more people go out." Relatives told us they considered the management approachable and open to any suggestions. For example, one relative said, "The manager is wonderful and communicative to me and very supportive to mum. I'm very impressed, no complaints at all." Other relatives commented on the openness and transparency of the management.

The culture of the service was based on treating people with dignity and respect and was focussed on meeting their needs and preferences. This was reflected in the values expressed by the staff and management. The views of people and relatives reflected this culture.

People and relatives said the way the service was managed reassured them. For example, one relative said, "I have every confidence in the management," and a relative commented, "I have 100% peace of mind. The home is well managed….approachable and friendly."

Staff said they attended staff meetings where issues about the care of people and how the service was managed were discussed. Staff said they felt able to discuss any issues they had with the provider or registered manager adding they felt both supported and valued. For example, a staff member commented of the provider and registered manager, "I can speak to them about anything. They are flexible and have the client's best interests at heart."

The home had a registered manager who was experienced and qualified for the role. The registered manager described the management of the service as "open and transparent" and made herself available to staff. Line management responsibility was delegated to the assistant manager and four senior care staff.

There were a number of systems of audit to check the safety and quality of the service. These included audit checks on fire safety, care plans, staff supervision, staff training and incidents. Records of falls and 'near misses' were maintained and showed action was considered to prevent possible reoccurrences. Records also showed the provider carried out regular checks which involved obtaining the views of people. The provider was observed spending time with people by talking to them, arranging activities and providing support.