Blackrod House Limited

# Blackrod House

**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? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

The unannounced inspection took place on 26 August 2015. This was in order to provide a rating for the service under the Care Act 2014. We were also responding to whistle blowing concerns made to the Care Quality Commission (CQC) about the care provision at the service.

Blackrod House is registered to provide accommodation for up to 30 people. A unit for people with varying stages of dementia is located on the first and second floors, while residential care is provided by the unit on the ground floor. The home is situated on the corner of the main road through the centre of Blackrod, near Bolton. Local shops and amenities are close by.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014. This breach related to the provision of safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe living at the home. There was an appropriate safeguarding vulnerable adults policy and procedure in place and staff demonstrated a good working knowledge of this.

The service had emergency plans in place and emergency equipment was well maintained. However there were some environmental risks identified, such as doors propped open, a non-functioning light bulb in an area with no natural light near the top of some stairs and rooms which were situated near the top of some stairs. Although there was a fire door and the lift was adjacent to these rooms the absence of light could have presented a risk to people who used the service who had a level of confusion.

Recruitment of staff was robust, involving appropriate procedures and checks to ensure staff were suitable to work with vulnerable people.

Medicines policies and procedures were in place but medicines were not always given safely.

The home specialised in dementia care, but staff were not able to say what dementia model they were working to. The environment lacked signage and other touches conducive to good dementia care.

Care plans included appropriate information, but were difficult to follow. They had been regularly reviewed to ensure information about care needs was up to date.

The service had a robust induction programme and training for staff was on-going. However, staff would benefit from more in-depth dementia training to ensure people living with dementia had their needs met appropriately.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People said the staff were caring, but we observed little natural interaction going on throughout the day. Staff concentrated on tasks to be completed rather than chatting with people who used the service.

Regular satisfaction surveys were undertaken to ascertain people's views of the service and we saw the most recent of these. Most people had made positive comments. Relatives' meetings provided a forum for people to raise any concerns, put forward suggestions and air their views.

The service had champions amongst the staff for dignity and end of life care. They ensured they kept up to date with information and disseminated it to the other staff members. People's wishes for the care they wanted when they were nearing the end of life, if they had expressed these, were noted within the care plans.

Personal information within the care plans was inconsistent, so that not all of them were person centred and individualised.

The home worked well with other agencies and there was appropriate documentation and correspondence with regard to other services kept within the care files.

There were a number of activities on offer at the home and the service had a dedicated member of staff to lead activities and trips out. There was a well-equipped sensory/relaxation room and a reminiscence lounge for people to use.

The service had an appropriate complaints policy in place and there was a complaints log which evidenced that complaints were dealt with appropriately.

There was a registered manager in place.The registered manager had little knowledge of what constitutes good dementia care and did not follow the service's own protocol with regard to infection prevention and control.

Staff supervisions and appraisals were undertaken regularly and staff were encouraged to access training and attend meetings.

Audits were undertaken but there was little evidence of any analysis of the results to facilitate continual improvement to care delivery.

Relatives' surveys were undertaken regularly to ascertain their views of the service provision.

# 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 consistently safe.

People told us they felt safe, there was an appropriate safeguarding vulnerable adults policy in place and staff had a good working knowledge of this.

The service had emergency plans in place and emergency equipment was well maintained, but there were some potential environmental risks identified.

Recruitment of staff was robust.

Medicines were not always given safely.

**Is the service effective?**

**Requires improvement**

The service was not consistently effective.

The home specialised in dementia care, but staff were not able to say what dementia model they were working to. The environment lacked signage and other touches conducive to good dementia care.

Care plans included appropriate information, but were difficult to follow. They had been regularly reviewed to ensure information about care needs was up to date.

The service had a robust induction programme and training for staff was on-going.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

**Is the service caring?**

**Requires improvement**

The service was not consistently caring.

People said the staff were caring, but there was little natural interaction going on and staff concentrated on tasks to be completed rather than chatting with people who used the service.

Regular satisfaction surveys were undertaken to ascertain people's views of the service and relatives' meetings provided a forum for people to air their views.

The service had champions amongst the staff for dignity and end of life care. They ensured they kept up to date with information and disseminated it to the other staff members.

**Is the service responsive?**

**Requires improvement**

The service was not consistently responsive.

Personal information within the care plans was inconsistent.

# Summary of findings

The home worked well with other agencies and there was appropriate documentation and correspondence with regard to other services kept within the care files.

There were a number of activities at the home and the service had a dedicated member of staff to lead activities and trips out. There was a well-equipped sensory/relaxation room and a reminiscence lounge for people to use.

Complaints were dealt with appropriately.

**Is the service well-led?**

**Requires improvement**

The service was not consistently well-led.

There was a registered manager in place. The registered manager demonstrated little knowledge of what constitutes good dementia care and did not follow the service's own protocol with regard to infection prevention and control.

Staff supervisions and appraisals were undertaken regularly and staff were encouraged to access training and attend meetings.

Audits were undertaken but there was little evidence of any analysis of the results to facilitate continual improvement to care delivery.

Relatives' surveys were undertaken regularly to ascertain their views of the service provision.

# Blackrod House

**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. 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The unannounced inspection took place on 26 August 2015. The inspection team consisted of two Adult Social Care Inspectors from Care Quality Commission (CQC) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. If the inspection included an expert-by-experience you should use this sentence 'An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held about the service such as notifications, safeguarding concerns and whistle blowing information.

Before our inspection we contacted Bolton local authority commissioning team to find out their experience of the service. We also contacted the local Healthwatch to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care.

During the inspection we spoke with seven people who used the service, two relatives and one professional visitor. We also spoke with five members of care staff, the registered manager, laundry and activities staff members. We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed records at the home including five care files, four staff personnel files, meeting minutes and audits held by the service.

Requires improvement

# Is the service safe?

## Our findings

We spoke with seven people who used the service and asked them if they felt safe. One person said, "Yes, well I don't go anywhere not to be safe." Another person answered, "Yes, I am looked after very well." Others spoken with confirmed that they felt safe.

There was a safeguarding vulnerable adults policy in place, which referenced other policies such as accidents, complaints and whistle blowing. We saw that staff had undertaken training in this area and had a good working knowledge of safeguarding issues and how to report them. We looked at the whistle blowing policy which included relevant information and guidance. We saw the accident book was not completed accurately, as pages had been ripped out of the book but stubs had not been completed. However, accidents were recorded within people's care files.

On our tour of the building we noticed that some people's rooms were situated close to the top of some stairs. The people who resided in these rooms had restricted mobility and one of them told us they suffered from memory problems. As an additional risk to the proximity of the stairs a light bulb in this area was not working. We raised our concerns with staff, who told us the people who used these rooms were not living with dementia, therefore were safe. The light bulb was not changed until much later in the day.

There was a roof garden and a ground level garden. No one was in the roof garden and we noted that only one person was seen to use the ground level garden on what was a warm and pleasant day. We saw that some bedroom doors were propped open, with folded paper or a chair. This meant that fire doors would not automatically close in the event of an emergency.

The service had an emergency and crisis policy in place and there was a Business Continuity Plan with contact numbers. Appropriate health and safety policies and procedures were also in evidence. We saw maintenance records for equipment at the service. These were complete and up to date at the time of the inspection.

We saw that there were fire extinguishers in place on all floors and there was evidence that fire equipment was regularly checked and maintained. A fire risk assessment was also in evidence. Fire drills were carried out at least twice per year, one drill being undertaken during the night to ensure all staff were aware of the requirements and responsibilities.

We looked at four staff files and saw that the recruitment was robust. The files included job application, job description, photo identification, two references, interview notes and Disclosure and Barring Service (DBS) checks. DBS checks help ensure people's suitability to work with vulnerable people.

We looked at recent staff rotas and noted the number of staff on duty on the day of the inspection. Some rooms were a distance away from the hub of the home and during the morning, on the ground floor, the senior carer was giving out medicines for a length of time. This left one person to cover the rest of the floor. We saw no checks taking place on people who chose to remain in their rooms away from the lounge areas. We were told by the owner and the registered manager that people had a buzzer to press to summon staff if the needed them.

When we arrived at the home we were told by a staff member on duty that two people had suffered bouts of severe diarrhoea during the night. Staff were still dealing with this and documented it in a medical book. We saw that the protocol advised early reporting to the Health Protection Unit if two or more people had diarrhoea. We spoke with the registered manager about this when she arrived and she informed the inspectors that one of the people was prone to regular bouts of diarrhoea. She therefore did not feel this required reporting as an 'outbreak'.

We looked at the medicines policy which was appropriate and included information and guidance for staff. General medicines including controlled drugs were stored appropriately and a controlled drugs register evidenced these were signed for by two people, as required. We saw that not all the medication administration records (MAR) sheets included a photograph of the person, which could lead to medicines errors occurring. Medicines belonging to people newly admitted to the home were booked in but had not been double signed in line with the home's policy. We saw that an antibiotic, required three times daily had

Requires improvement

# Is the service safe?

not been signed for as given at tea time. However the tablet had gone from the box. Topical medicines, such as creams, had not been signed as having been applied and some were stored in people's bedrooms.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

# Is the service effective?

## Our findings

We were shown around the premises by staff and saw that there were three levels to the home. People who were living with dementia had bedrooms on the first and second floors. When we arrived we noted that in three rooms, where people were still asleep, the main lights had been left on. We saw within the care plans we looked at that some people liked a light on at night. We discussed with the owner that a small lamp may be more conducive to sleep in preference to leaving the main light on at night. The premises were clean but we noticed some malodours around the building.

The service specialised in dementia care, but we saw little evidence of this specialism around the home. Most of the rooms had memory boxes, people's names and/or photographs on the doors. However, there was a lack of signage around the building to orientate people to their surroundings. The lighting was not very bright in some areas and there was nothing tactile along the corridors for people to touch. There was a pleasant roof garden and a ground floor garden area with seating and a bus stop. However people were not seen to be encouraged to use these areas. When we asked staff which dementia model they were working to, they demonstrated no understanding of what was meant by a dementia model.

We observed both the breakfast and the lunch time meal on two floors. We saw that, on the ground floor, people were not encouraged to eat in the dining room and there was little social interaction during mealtimes. No menus were in evidence although the owner later showed us some pictorial menus that had been put together. One person who used the service told us at breakfast, "These cornflakes are soggy". Another was served porridge that was extremely thick and so hot they nearly burnt their mouth and had to ask for cold milk to be put on it. At lunch time we again noted that people were not encouraged to sit in the dining room and eat together and staff only assisted or prompted people when they appeared to be falling asleep. Five people sat in the dining room on the ground floor and one described the soup served to them as "Thick and tasteless". The soup was followed by a roast chicken dinner, which looked appetising or an omelette. One person who used the service told us, **"**The food is good. There's always two choices." We saw that the tea time meal was fish fingers and chips, baked beans were optional. We asked what people who required a pureed diet would have and were told it would be the same meal, but blended.

We looked at five care plans which consisted of a health action plan and a care file. The files included information about health and support needs, but some were incomplete. One had no care plan to manage the person's particular health condition. Another had a note that the person was living with dementia, but did not state the type of dementia. There were daily reports and recorded weights, risk assessments relating to issues such as falls and catheter care. However, some of the papers within the files were mixed up and this made them difficult to follow.

Agreements and consent forms had not been signed by the person who used the service or their relatives. Although staff were aware of the need for consent and we saw verbal consent for care interventions being sought, consent and agreement was not formally documented within the care plans.

We saw that the service facilitated regular appointments with the other services such as the optician and chiropodist. These appointments were sometimes made with people's relatives who would transport them to the location. Some services visited the home to carry out care and treatment. GP and hospital referrals were made appropriately and correspondence between the agencies was evident in people's care files. The care files had been reviewed regularly to help ensure their care and support needs were kept up to date.

Staff had undertaken a comprehensive induction programme, including mandatory training. New staff were undertaking the Care Certificate which was brought in to replace the Common Induction Standards and National Minimum Training Standards in April 2015. Training was on-going, including refresher courses in the mandatory subjects. Supervisions and appraisals were undertaken on a regular basis to assist staff to identify their progress and on-going training needs. Staff had undertaken basic dementia training, but would benefit from more in-depth training in this area, as the home specialised in dementia care.

We looked at the Deprivation of Liberty Safeguards (DoLS) applications and authorisations. These are applied for when people need to be deprived of their liberty in their

Requires improvement

# Is the service effective?

own best interests. This can be due to a lack of insight into their condition or the risks involved in the event of the individual leaving the home alone. The Care Quality Commission is required by law to monitor the operation of the DoLS and to report on what we find. The service had DoLS in place where appropriate and had consulted other professionals, such as the specialist dementia team, to assist them when required, for example, during periods where people displayed behaviours that challenged the service. We spoke with staff members, who demonstrated an understanding of the DoLS process. However, a senior staff member was unsure of who was currently subject to a DoLS authorisation.

We looked at Mental Capacity Act (2005) (MCA) and the best interests decision making process. MCA is used when people lack capacity to make particular decisions for themselves. We saw evidence within care files that best interests decisions had been made with regard to people who lacked capacity.

Requires improvement

# Is the service caring?

## Our findings

We spoke with seven people who used the service. One person told us, “They are very good to me”. Another said, “This is the best place we have been”. When asked if they were treated with respect and dignity one person said, “Well I suppose so”. A visitor said, “If I didn’t [visit every day] the staff can’t guarantee that they can give [my relative] the help that she needs”. Another said, “The place seems homely”.

We spoke with a visiting professional on the day of the inspection. They told us they had been visiting the home for a few weeks and found the staff very helpful and had no issues with the service.

On observing the care at the home we saw that staff were kind and considerate when attending to people’s needs. However, although people were given the basic care they required staff concentrated on completing tasks and there was little or no natural interaction and engagement in evidence between people who used the service and staff. Some people who used the service were left to struggle at times, for example when eating their meals, and staff missed opportunities to provide encouragement and assistance to those who required it. We did not observe staff taking the time to build people’s confidence or motivate them to use their strengths and abilities to be as independent as possible.

There was a confidentiality policy in place. However, during our inspection we saw that some records containing personal information about people who used the service had been left out in the dining room. This meant that any visitor to the service would have access to this information and was not in line with the service’s confidentiality policy. We spoke with the registered manager about this and the documents were moved to a more secure location immediately.

The service produced a service user guide which included information about the staffing structure, mealtimes, activities and the statement of purpose. This was given to people who may wish to use the service, or their relatives. A copy of the service user guide was also placed in each person’s room for them, or their families, to refer to whenever they wanted to.

The service had champions amongst the staff for dignity and end of life care. These were members of staff who took the lead in these areas, kept up to date with changes and disseminated this information to other staff members. Staff had received training in end of life care, which was included in their induction programme, to help ensure people were given the care and treatment they wanted as they neared the end of their lives. We saw that people’s wishes for their end of life care delivery, if they had expressed these preferences, had been documented within their care plans.

Requires improvement

# Is the service responsive?

## Our findings

We reviewed five care plans and looked at people's preferences for their daily routines. Documentation about people's likes and dislikes, preferred times of rising and retiring were inconsistent within the care plans. We observed approximately 11 people up and dressed when we arrived at 6.45 am and others dressed but still in their rooms. It was unclear whether this was people's choice, but although some people were wide awake and enjoying a cup of tea, others were still sleepy and we were told by the senior on duty they had not been offered the opportunity to go back to bed, after being changed, to enjoy a little more sleep.

Within the five care plans we looked at we saw that some included personal information, life history, likes and dislikes, but others had little information in this area. The ones with the best information were those where family had supplied this to the home. This meant that the care plans were not always person centred and individualised. We spoke with the registered manager about this and she told us the service planned to implement a 'resident of the day' which would consist of checking one person's care records every day and ensuring they were complete. This would help them ensure all care plans would be complete and up to date.

We observed that staff did not always respond to people's needs, for example some people did not receive the assistance they required at meal times, which in some cases may have only consisted of some encouragement to sit at the table and eat their food.

There were a number of activities on offer and there was a designated activities room with large tables, which housed arts and crafts materials and board games. The activity board displayed information about Zumba and fitness on Tuesdays and Thursdays, but there was no pictorial guide to activities, which would be easier for people living with dementia to relate to. On the morning of the inspection there was a session of exercises to music taking place and the people who joined in enjoyed this very much.

There was an activities co-ordinator who worked five afternoons per week. She engaged those residents who wished to join in in various activities and told us that she arranged trips out. They often used Dial–a-Ride buses when they were available, to go within a six mile limit, as bus passes could then be used. Other trips included a day out to Southport, Blackpool lights and a Christmas lunch out. There were also singers and entertainers brought in regularly to entertain the people who used the service.

The home had a sensory room which people could use for relaxation if they wished. There was also a hairdressing room, where people could have their hair done regularly. However this room was quite dirty on the day of the inspection, with some dirty communal hairbrushes in evidence. We discussed with the registered manager and the owner making this into a more welcoming and pleasant hairdressing salon for people who used the service.

We saw that there was a reminiscence lounge, decorated and furnished in the style of the 1950s. This was a well put together room, which people living with dementia could relate to and enjoy relaxing in.

People who used the service were encouraged to give feedback about the service via satisfaction surveys. We saw the results of this year's survey which included many positive comments about the care. One comment was, "All staff are usually welcoming and friendly". The feedback was discussed at a subsequent relatives' meeting as well as discussions about food choices, laundry and toiletries. This forum gave people the chance to air their views and raise any concerns about the service.

There was a complaints procedure in place. We asked people if they were aware of how to make a complaint. One person who used the service said, "I have been here two and a half years, and I think the Care is good. I have no complaints, but if I did I would talk to the management". We looked at the complaints log which was complete and up to date, complaints having been responded to appropriately.

We saw some recent thank you letters. Comments included, "Thank you again for all your kindness".

Requires improvement

# Is the service well-led?

## Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

When asked why the infection control protocol was not followed, until the matter was pressed by the inspector, the registered manager said they did not feel the issue was severe, even though it had been described as such in the notes written by the care staff. The registered manager did not follow the service's protocol on the day of the inspection.

One visitor we spoke with said "If I can be truthful with you, I will say that the carers are caring and try their best, but the management leave a lot to be desired."

We spoke with the registered manager about what constituted good dementia care, but her understanding of best practice in this area was limited. She was unable to tell us anything about dementia models of care or which model the service followed.

We brought to the attention of the registered manager the fact that some fire doors were being propped open, meaning some parts of the building may not be safe, and she was unaware of this.

We spoke to the registered manager about people leaving the dining table before the meal was over and her answer was, "They always do", rather than looking into why this was the case and what could be done to encourage people to fully participate in the dining experience.

We saw that the service sent out regular relatives' satisfaction surveys. There were positive comments about the care among the latest returns, and some negative comments about the environment. The service held regular relatives' meetings which provided a forum for people to raise any issues or concerns and to make suggestions.

Staff had regular one to one supervision sessions and yearly appraisals and we saw evidence of these meetings. We saw that staff were encouraged to access training to enhance their knowledge and skills. There were also staff meetings held where discussions included handovers, medication issues, documentation and staffing issues. Staff we spoke with felt the registered manager and the owner could be approached if they needed to speak with them about anything.

Although appropriate policies and procedures were in place at the service many of these were in need of review and updating. We spoke with the registered manager about this and she agreed to review all policies in the immediate future.

There were a number of audits in place, such as care plan audits, medication audits, accident audits and monthly weight audits. These were complete and up to date and identified issues, such as the medication errors we had seen. However, there was little evidence that the results were analysed to help ensure continual improvement to care delivery.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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<br><br>How the regulation was not being met:<br><br>The registered provider had not adhered to the proper and safe management of medicines. Regulation 12 (2) (g) |