Blacklake Lodge Ltd

Blacklake Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Blacklake Lodge Residential Home is a residential care home which provides accommodation and personal care to a maximum of 37 older people. On the day of our inspection, 23 people were living at the home, most of whom were living with dementia.

People's experience of using this service and what we found
Environmental risks were not managed safely and the provider had failed to protect people against the risk of scalding. People had been placed at risk of harm because staff did not follow good infection control practices.

People's medicines were not always safely managed by staff, resulting in some medicines not being stored at the correct temperatures. People's medicines were not always monitored so staff did not know how effective they were. The staffing arrangements at night were not always maintained at a safe level, which put people at risk of not having their needs safely met.

Following our previous inspection, we had imposed conditions which the provider had not fully complied with and they had not informed us of staffing issues at night. The provider had not driven improvement in the quality and safety of the service, which had put people at risk of harm.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was inadequate (published 31 December 2019).

At this inspection improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We had previously carried out an unannounced comprehensive inspection of this service on 25 October 2019. Breaches of legal requirements were found and we imposed conditions on the provider's registration.

This inspection was prompted in part due to the provider not having suitable insurance for the home. We undertook a focused inspection to review the key questions of safe and well-led and to look at any improvement the provider had made since our previous inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Blacklake Lodge Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safety, medicines, staffing, leadership and governance at this inspection.

Please see the action we have taken at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Blacklake Lodge Residential Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector and one assistant inspector.

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

The service had a manager but they were not registered with the Care Quality Commission. This means the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with nine members of staff including the manager, deputy manager, cleaning and care staff, the activities co-ordinator and one of the directors.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested evidence of moving and handling equipment servicing, portable appliance testing and legionella testing.

We spoke with the directors of the service, one of whom was the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The provider had not protected people from the risk of scalding. The Health and Safety Executive advises hot water temperatures for care homes should not be above 44°C. Staff checked water temperatures monthly in people's rooms and had consistently recorded unsafe hot water temperatures of up to 50°C since January 2020. Staff told us the provider adjusted the water temperatures as they reported the unsafe temperatures. However, water temperature checks were only completed once a month. The provider had failed to take any long term action to mitigate this risk. People, therefore were placed at a significant risk of scalding and serious injury.
● The provider had not ensured staff recorded people's distressed behaviour in a meaningful way. People's risk assessments and care plans had improved since our previous inspection. However, the records staff completed when people were anxious or distressed did not give enough detail about potential triggers and actions they had taken. The manager told us there was no evidence of staff collating or analysing these records. By not monitoring the support given to people who are distressed, the provider cannot be assured risk assessments are effective at keeping people and others safe.
● At our previous inspection there was no system in place to identify concerns and learn lessons when things went wrong. Although the systems had been improved and staff understood their responsibilities better, there were still concerns which had not been reported by staff.
● The provider had not ensured staff took the required action to mitigate risk. One person, who was at risk of falls, required staff to complete night welfare checks at specific times throughout the night. The person's records did not show these were completed at the required time intervals. This placed the person at risk of harm through falls or neglect.
● The provider had not ensured the risk of Legionella was reduced. Legionella is bacteria found in water systems and can cause respiratory disease. The provider told us they were not required to complete Legionella tests because they had no water storage tanks at the home. The Health and Safety Executive states a risk assessment must be carried out as there may be other factors, such as showerheads which can store water and increase the risk of Legionella being present. The provider told us there was not a risk assessment of their water system, therefore they could not provide evidence of how the cleanliness of their

water system was maintained in the absence of Legionella testing. This placed people at significant risk of harm.

Preventing and controlling infection

● The provider had not ensured staff followed the systems in place to protect people from the risk of infection. Staff use of personal protective equipment (PPE) did not meet the current national guidance for Coronavirus (Covid-19).

● Staff were observed pulling their masks down below their noses on numerous occasions throughout our visit. Staff pulled their masks down when talking with people, other staff and walking around the home. Staff did not respect social distancing and the putting on and taking off of their PPE was not done in a way to help minimise the spread of infection. People were put at a significant risk of infection because staff practice did not help to control the spread of any potential infection within the home.

● Staff did not clean moving and handling equipment, such as hoists, after each use. The cleaning of equipment helps to prevent the spread of any potential infection and is current national best practice for the prevention of infection.

● Staff told us they had received training in infection control. The local authority had also provided training and guidance within the home shortly before our inspection. The manager told us staff had received instruction in how to use PPE effectively and this had also been discussed at meetings. During our inspection, the manager and the inspection team reminded the staff team about safe practice when wearing PPE, however, staff chose not to follow safe practice. These practices put people and staff at a significant risk of harm.

Using medicines safely

● The provider had not ensured people's medicines were safely managed. Despite significant improvement since our previous inspection, we continued to find issues with the management of medicines.

● The provider had not ensured staff were competent to handle medicines safely to minimise the risk of cross infection. Staff had poor infection control practice when handling people's medicines, which included not washing their hands in between supporting people to take their medicines.

● The provider had not ensured the effectiveness of people's medicines had been monitored. Some people required medicines to be given only when they needed them, for example pain relief. When staff gave these medicines, they did not record why the person needed the medicine or if the medicine had the desired effect.

● The provider had not ensured people's medicines were stored at the correct temperature. One person's medicine was stored in a medicine fridge. For the three days prior to and the day of our inspection, the temperature of this fridge had been above the recommended temperature which was too high to safely store it. Staff were aware of this but had taken no action to seek advice on whether the medicine was still safe to use. Storing medicines at the correct temperature ensures they stay effective and prevents bacterial growth. Following our inspection, the manager informed us the medicine and the fridge had been replaced.

This is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were enough staff to safety meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At our previous inspection, the provider had not met their own minimum staffing levels. At this inspection we found although day time staffing was improved, night time staffing was not always sufficient.
● The provider's staffing level for nights was three staff. Staff told us there was often just two staff working at night, which placed people's safety at risk. We saw for the eight nights prior to inspection there were five nights when only two staff had worked. One staff member said, "We only have two night staff on duty regularly, all the staff think this is unsafe."
● People's wishes were not able to be met because not enough staff worked at night. One person told us, "The only change I would make would be to have more staff. I wanted to get up at 6.30am this morning, but because there are only two members of staff, they couldn't help me. I waited until 8am to get up."

This is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● At our previous inspection, staff did not always report concerns which related to abuse. Therefore people had not always been protected against the risk of abuse. Action was already in progress to improve staff knowledge. At this inspection, we found these improvements had been sustained. The manager told us staff reported concerns to help ensure people were protected from the risk of abuse. We confirmed this through conversations with staff and the records we viewed.
● People told us they felt safe living at the home and when staff supported them. One person said, "I feel very safe, I can lock my door at night."

Inadequate

Is the service well-led?

Our findings

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

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

At our last inspection the provider had failed to ensure there were effective systems in place to monitor the service and mitigate risks to people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Continuous learning and improving care

- The provider has a history of not achieving the required standards for delivering safe, effective, caring, responsive and well-led care to people. The provider has failed to achieve an overall rating of good in their last five inspections. This has placed people at a continued risk of unsafe care.
- The provider has failed to comply with their conditions of registration. Following our previous inspection, we imposed conditions onto the provider's registration. One of these conditions of registration was for the provider to inform us if their staffing levels fell below their assessed staffing levels. During this inspection, we found the provider's staffing levels at night had fallen below their assessed level. We also are aware that since our inspection this has happened again. The provider has not informed us of these incidents, which placed people's health, safety and welfare at risk.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had received on-going and intensive support from the local authority since our previous inspection. However, they had failed to demonstrate any significant improvement. Specifically, two weeks prior to our inspection, the local authority had supported the provider with infection prevention and control training and guidance at the home. Despite this, as identified at this inspection, staff did not follow national guidance and significant improvement in this area was still required.
- Staff told us the culture at the home was not always a positive one. One staff member told us there was often staff confrontation and arguments between staff which were within people's hearing. Staff told us of tensions within the staff team which showed there was not always supportive relationships between staff. This behaviour did not support an open culture where staff felt able to talk freely about their concerns and work as a cooperative team.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal

responsibility to be open and honest with people when something goes wrong

● The manager told us staff responsibilities had not been clearly defined, therefore not all records were checked prior to being archived. Because of this the manger was not aware one person who was at risk of falls had not consistently received their welfare checks during the night. This placed the person's health, safety and wellbeing at risk.

● The provider had not ensured they had effective oversight of the service to minimise the potential risks to people's health, safety and wellbeing. No registered manager been in post at the home since July 2019. The current manager had started work at the home after our previous inspection but had not yet registered with us. Although the provider had quality systems in place these were not robust enough for them to identify the failings in the service.

● Records relating to the health and safety of the environment were not easily accessible. At the start of our visit the manager told us some of the health and safety records we requested were not available. This was because the provider was not available on the day of our inspection and the records were locked away in their office. We asked for these records to be forwarded to us by a specific date and time. The provider failed to comply with this request.

● Following our inspection, we requested information relating to water temperature checks to be forwarded to us. This was to seek reassurance from the provider about the risk of harm to people and the confirmation of actions they had taken. The provider failed to respond or comply with this request for information.

The provider's poor governance did not ensure a continuous improvement in the quality and safety of care for people. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made attempts to secure insurance for the home but had not been successful. They informed of this prior to our inspection and we were aware the impact of the current Covid-19 pandemic had been a contributing factor in them not being able to obtain insurance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some people attended regular meetings at the home so they could give their suggestions for improvements. We saw the suggestions people made had been put into place, such as more fruit and specific food items on the menu. The manager told us they and staff also spoke with people daily and so ensured everyone could give feedback and suggestions.

Working in partnership with others

● People were supported by the partnership working in place at the home. The provider had maintained links with external professionals, such as GPs and mental health teams, to help ensure people's health needs were reviewed as required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured service users were protected from the risk of scalding. Service users were placed at risk of harm because the provider had not ensured staff followed good infection control practices or managed and stored medicines safely.

The enforcement action we took:

We imposed an urgent condition on the provider's registration.