Blueberry Transitional Care Ltd

Sandford Road

Inspection report

94 Sandford Road
Birmingham
West Midlands
B13 9BT

Tel: 01217920161

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15 July 2020
16 July 2020
17 July 2020

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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
Sandford Road is a residential care home providing personal care and accommodation to six people with a learning disability. At the time of the inspection six people lived at the home.

The service has been designed taking into account best practice guidance and the principles and values underpinning Registering the Right Support (RRS) in respect of the environment. The building design fitted into the residential area as it was domestic in style in keeping with other homes in the street. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
We found people were not always safeguarded by the systems in place in relation to the use of physical intervention and lessons were not always learned about how to better support people during periods when they present behaviours that challenge.

Staff were not always recruited safely as not all required checks had been undertaken prior to commencing work at the home.

Staff were not always following current government guidance in relation to COVID19 and the use of personal protective equipment.

People received their medicines when needed and staff where trained to administer people's medicines safely.

Peoples support plans where not always updated to ensure they reflected people's individual needs and had not considered the impact of COVID19 restrictions on people using the service.

A lack of oversight meant potential risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service were not effective and had not identified the areas for improvement found at this inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was Good. (Published 06 June 2019).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding, use of restraint, care being provided, financial issues and the environment. Additional concerns were shared with us by the

Clinical Commissioning team. A decision was made for us to inspect and examine those risks.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID19 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 person centred care, safeguarding, recruitment practices and governance.

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

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Sandford Road

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 three inspectors. Two inspectors visited the home on the 16 July 2020, whilst the third inspector undertook telephone calls to staff and relatives.

Service and service type
Sandford Road 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 did not have a manager registered with the Care Quality Commission.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with COVID19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

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

During the inspection
We saw all of the people that lived in the service, however people living in the service were unable to

effectively communicate with us on their safety or the effectiveness of leadership in the home. We spoke with six relatives about their experience of the care provided to their family members. We spoke with six members of staff, the maintenance person, manager, operations area manager and provider. We also spoke with two healthcare professionals.

We reviewed a range of records. This included three people's care records and medication records. We looked at two staff files in relation to recruitment. We also looked at records that related to the management and quality assurance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Systems and processes were not established or operated effectively to prevent potential abuse of people living at the home.
- Staff supported some people that displayed behaviours that may challenge others. We found where restraint was used, the records did not always detail the actual duration of the restraint, the de-escalation techniques used prior to the restraint being imposed, and the position of the staff members implementing the restraint. This meant it was not clear and transparent if the restraint used was the least restrictive and for the shortest possible time.
- Staff we spoke with and the records we reviewed, confirmed a manager / provider did not always review the physical incident records to check the details provided. This meant checks were not undertaken to ensure the restraint implemented was proportionate to the distressed behaviours displayed by people.
- The manager confirmed analysis of the incidents of restraint and distressed behaviours displayed had not been regularly reviewed. Therefore, the records staff completed, and staff knowledge was not utilised to identify any patterns and trends in people's behaviours or any potential triggers.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke with four relatives about how risks relating to their family members were managed. One relative told us, "[Person] has started showing behaviours they have not had before, these have not been managed and they are behaviours that put [person] at risk of harm." Three relatives told us they were happy with the support their family members received and staff knew their family member well and knew about any risks associated with providing their support. A relative said, "Staff know [relative] and they know how to provide support in their best interests."
- Risk assessments were in place and detailed the risks staff needed to be aware of. However, these did not always contain the most up to date information for staff to refer to, and for one person a risk assessment referred to another risk assessment which was not in place.
- Staff we spoke with were able to tell us about the risks they needed to be aware of when supporting people. One staff member said, "(Persons name) can become agitated and anxious if they are not able to do the things they want."
- Staff were aware of their responsibilities to report and act on any safeguarding concerns. A staff member told us, "We have a duty of care for people here, if there was something not right, I would pull them up and speak and report to the manager".
- We saw some fire doors were being propped open by door wedges which placed people at risk in the

event of a fire. The manager told us this had been raised with the provider and door fittings would be purchased to ensure the doors could be kept open safely.

Staffing and recruitment

● We reviewed the recruitment files for two recently employed staff. We saw in both files there were gaps in the staff members employment history that did not have an explanation. Neither files contained evidence to support a disclosure and barring check had been completed prior to the staff members commencing employment. The manager did produce evidence of disclosure and barring checks for both staff on the day of the inspection. References for both staff were not dated when they were completed and received by the previous manager. References had not been validated to ensure they had been checked as accurate. This meant recruitment processes were not always effective in ensuring staff were suitable for the roles prior to employment.

This was a breach of regulation 19 (Fit and Proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff and relatives told us sufficient staff were on duty to meet people's needs. The staffing levels were as required in accordance with the assessed needs of people and as agreed by the funding authority. A relative told us, "There are always lots of staff on when we have visited."

Preventing and controlling infection

● Only one member of staff was observed to be wearing a face mask. However, they were not wearing it in line with the government guidance for preventing the spread of COVID19 as the mask did not cover their nose and mouth.

● The manager told us staff were not wearing face masks due to the impact these would have on the people they supported, there was no evidence other professionals had been consulted on ways to support people get used to masks. A risk assessment had not been completed in line with government guidance for each person stating what these risks were. However up to the day of the inspection, there had been no confirmed cases of COVID19 in the home.

● We saw the flooring in the communal area was in need of repair as it was worn through and several light bulbs did not work in the communal areas of the home. The manager told us improvements were being made to the environment, and the flooring was next to be replaced now the redecoration had been completed. The manager said the light bulbs would be replaced immediately.

Using medicines safely

● We reviewed the medicine records which confirmed people received their medicines as prescribed and medicines where stored appropriately.

● Staff confirmed they had received medicines training and had their practice observed to ensure they were competent in this area.

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

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

- People's support plans were not always detailed to reflect their needs. For example, one person had specific needs and routines which they followed. However, specific information was not provided to ensure staff had access to consistent and detailed information therefore staff were not able to provide people with person centred care and support.
- Staff we spoke with were able to tell us about some of these routines but not in detail, however staff knew routines were important to the person though did not know why they were important to the person. One staff member told us, "[Person] has a few [routines] and does not like them being broken."
- People's support plans had not been updated to consider the impact of COVID19 on their needs and daily routines. Staff told us, and the records we reviewed, showed people enjoyed accessing various activities in the community. People were unable to engage in these activities when they were closed due to the restrictions imposed due to COVID19.
- Support plans and people's daily routines had not been updated to take into consideration the impact COVID19 restrictions would have on people and the alternative activities that people could participant in external to the home. Staff told us people undertook activities internally and accessed the garden area.

This was a beach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes were not effective in reviewing and maintaining oversight of the service being provided.
- The provider confirmed they did not have any systems in place to monitor the quality of the service provided until the appointment of an operations area manager in November 2019. We were informed there were no records to support what systems were in place by the previous manager of how they monitored and maintained the service provided. Although an audit and service improvement plan has now been completed, timely action has not been taken to review and monitor this and the improvements that should have been made by the timescales recorded.
- The lack of audit systems and processes meant incident reports of restraint used within the home were not reviewed to ensure they were completed in full. In addition, the lack of systems meant these reports had not been analysed to support the ongoing review and management of people's distressed behaviours.

● The lack of robust systems meant people's finances were not always managed appropriately. The provider told us following the resignation of previous employees, the receipts for ten months of expenditure for people's money in 2019 could not be found. An internal investigation has been undertaken and lessons learnt in response to this and new systems and recommendations were being implemented.
● The lack of effective audits meant people's care plans and risk assessments were not always reviewed and updated to ensure staff had access to consistent and accurate information about people's support needs.
● People's support plans, and routines had not been updated to take into consideration the impact COVID19 had on people due to the restrictions in place. Audits had failed to identify this, therefore not ensuring risks were effectively assessed, monitored and mitigated.
● Some people received medicines 'when required' (PRN) depending upon their wellbeing. We found for one person their consultant had changed the way they received this type of medicine, but this change had not been updated in their records to under pin this practice. The person's PRN protocol had been implemented in June 2018 and we found no evidence this had been reviewed however staff we spoke with were aware of this change.
● Audit systems and processes had not identified the errors we found in recruitment processes.
● Staff and the manager where aware of government guidance in relation to PPE. However, systems in place to monitor staff practice did not identify staff were not compliant. Systems failed to identify the required risk assessments had not been completed to demonstrate the reasons why staff were not following government guidance and wearing face masks to protect people and themselves from the transmission of COVID19.

The lack of governance systems and oversight meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service has not had a registered manager since April 2020. A new manager has been recruited and working in the home for eight weeks at the time of inspection. They acknowledged the shortfalls we found in the service and advised they were working towards addressing them. They were also addressing the action plan the local authority had given them following their visit to the home and their own internal improvement plan.
● The provider had met their legal responsibilities ensuring their inspection rating was displayed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A relative we spoke with advised staff had supported people to maintain contact with them during the restrictions implemented in response to COVID19. However, relatives told us the previous manager and provider had not actively sought their feedback about the service that was provided to their family members. A relative told us, "Staff will answer any of my questions and tell me about (person) but I have not received any surveys or been formally asked about (person) care. We have not had any formal discussions about the impact of COVID19 on (person) and their daily routines."
● Staff told us they felt supported in their role by the manager. One staff told us, "I honestly think the manager here now has made a positive change on the residents and staff. I feel I am supported by my manager and the director as well."

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 and provider understood their responsibilities in relation to the duty of candour regulation.
● Both the manager and the provider were receptive to our feedback and advised us of their commitment to making the required improvements.

Working in partnership with others;

● The manager and provider had been engaging on a regular basis with the local authority during the COVID19 pandemic. This evidenced partnership working between the home and external professionals to enable positive outcomes for people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to completed pre-employment checks to ensure fit and proper persons employed

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure peoples support plans were person-centred

The enforcement action we took:

We imposed a positive condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure the use of restraint was the least restrictive for the shortest time and analysis was completed.

The enforcement action we took:

We imposed a positive condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had oversight of the service provided

The enforcement action we took:

We imposed a positive condition on the providers registration.