Southwark Park Nursing Homes Limited

Blenheim Care Centres

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Blenheim Care Centres on 2 November 2016. The inspection was unannounced.

Blenheim Care Centres is a nursing and residential care home for up to 80 people located near Gainsborough, West Lincolnshire. The home is divided into three units, Blenheim House, Blenheim Lodge and some semi-independent flats. Blenheim Lodge was closed for refurbishment on the day of the inspection.

The home caters for people whose ages range from 18 years and above, and who have physical disabilities and/or neurological conditions. On the day of our inspection 24 people were living at the home as full time residents. One person was receiving regular respite care

A manager was in post who had not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 manager was not present at this inspection.

We carried out an unannounced comprehensive inspection of this home on 9 August 2016 during which breaches of legal requirements were found. In regard to Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment, we told the registered provider that they must become compliant by 31 August 2016.

We carried out a focused inspection on 21 September 2016 to check that the provider had taken action to ensure that they now met legal requirements. During the inspection we found that although the provider had taken some actions, they had not made sufficient progress to become compliant with the previously identified breaches of legal requirements. Following this inspection we imposed conditions of registration on the registered provider. These conditions meant that the provider was required to take specific actions to improve the service and meet legal requirements.

This focused inspection took place on 2 November 2016 and was unannounced. We undertook this focused inspection following further concerns we had received and to check that the provider had taken action with regard to issues raised by ourselves and other agencies who commission care for people living at the home. We also wanted to confirm their progress against requirement notices and conditions of registration which were put in place following the inspections on 9 August 2016 and 21 September 2016. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection; by selecting the 'all reports' link for Blenheim Care Centres on our website at www.cqc.org.uk.

At this inspection we found that the provider had made improvements to the way in which medicines were managed. People had received their medicines in the way in which they had been prescribed for them.

There had been a number of improvements to the ways in which risks to people's health, safety and welfare were managed. Risks associated with people's individual needs had been identified and planned for. Staff followed individual risk management plans when providing care.

A number of improvements had been made to the way in which quality assurance systems were managed. The provider was adhering to the conditions of registration we imposed at the focused inspection on 21 September 2016.

However these improvements were not sufficient to change the ratings for these key questions and had not been tested for sustainability.

There were continuing concerns regarding staffing levels and deployment, infection control measures and the quality of training for staff related to safeguarding people. Further concerns which required improvements to be made were identified regarding arrangements for supporting people to express their needs and views, induction training and support for staff and team leadership.

This meant that provider continued to be in breach of Regulation 12, Regulation 15, Regulation 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently taking action against the provider to ensure that they make the necessary improvements to become compliant with legal requirements.

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 consistently safe.

Medicines were managed in a safe way.

Risks to people's health safety and welfare were not robustly managed.

There were not enough staff to ensure people reliably received the care they needed.

Arrangements for the security, housekeeping and maintenance were not robustly managed.

We could not improve the rating for this key question from inadequate because the provider had not made sufficient improvements to meet the legal requirements.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality assurance systems did not consistently deliver improvements to the care people received.

Systems for ensuring that everyone who lived in the home was able to express their needs and views were not robust.

Management arrangements did not sufficiently support staff or foster a team working approach.

We could not improve the rating for this key question from requires improvement because the provider had not made sufficient improvements to meet the legal requirements.

Blenheim Care Centres

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 was 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.

This inspection took place on 2 November 2016 and was unannounced. The inspection team was made up of two inspectors.

This inspection was carried out as a result of concerns we received from other agencies. The inspection was also carried out to check that improvements had been made to meet legal requirements after our comprehensive inspection on 9 August 2016 and our focused inspection on 21 September 2016. We inspected the home against two of the five questions we ask about services; is the service safe and well-led? We also looked at progress by the provider against the conditions of registration we had put in place following our previous inspection.

We looked at the information we held about the home such as notifications, which are events that happened in the home that the provider is required to tell us about, and information that had been sent to us by other agencies such as service commissioners.

We spoke with four people who lived in the home. We looked at eight people's care records, including medicines records. We also spent time observing how staff provided care for people to help us better understand their experiences of care.

We spoke with seven staff members. We looked at the supervision and induction arrangements for two staff and staff duty rotas. We also looked at records for monitoring and assessing the quality of the service provided within the home.

Inadequate

Is the service safe?

Our findings

At our inspection on 9 August 2016 we found that the registered provider had not ensured that people received their medicines in a safe way. In addition, the registered provider had not ensured that risks to people's health, safety and welfare had been suitably assessed, managed and reviewed. This was a breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

At our inspection on 21 September 2016 we found some improvements had been made to the way medicines and risks to people's health, safety and welfare were managed. However, continued shortfalls in these arrangements meant that people were still at risk of not receiving care and treatment in a timely and consistent manner. Following this inspection we imposed conditions of registration on the registered provider. These conditions meant that the provider was required to take specific actions to improve the service and meet legal requirements.

During this inspection we found that the provider had made improvements to the way in which medicines were managed. We saw that medicines which required extra checks and special storage arrangements were managed correctly. The medicines store room and fridge temperatures were recorded daily and were within recommended limits. A registered nurse was able to describe the action they would take if the temperatures were outside of recommended temperature limits. Stock balances for medicines supplied outside of the monitored dosage system were recorded and we found them to be correct on the day of the inspection.

We looked at the medicine administration records (MAR's) for eight people and found that medicines had been given consistently. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person declined their medicines. There were clear instructions in care plans for any special requirements or preferences people had regarding their medicines. Protocols were in place for administering medicines which were prescribed to be given only as and when people needed them; known as 'PRN'. Best interests decisions had been made so that, where necessary, medicines could be given to people in their food or drink without their knowledge or consent. These decisions were only made where people had limited mental capacity to make decisions about their own care and treatment. Records showed who had been consulted in order to make best interests decisions.

The manager had implemented a system of regular audits for the management of medicines. We saw that action was taken to address any identified shortfalls. The manager had begun to send regular reports of their medicines audits and management systems to CQC in line with the conditions applied to the provider's registration.

During this inspection we found that the provider had made some improvements to the way in which they assessed, managed and reviewed risks to people's health, safety and welfare. Plans were in place, for example, to reduce risks associated with medical conditions such as epilepsy, diabetes and the use of bed rails. During the inspection we saw that staff followed risk management plans to effectively support one person with their behavioural needs. However, further improvements were required to the way in which risks

were identified and managed. An example of this was that actions to support a person who was at risk of harm from frequent unobserved falls were not always followed through. When we looked at their risk assessment and care plan we saw that they had experienced three falls in the previous four weeks. Their care plan review recorded on 15 September 2016, "Needs two carers for all needs." However, this had not been actioned. We saw that a new safety helmet was ordered on 12 October 2016 but had not yet been delivered. This would protect the person's head when they had a fall. Also, a pressure mat that would alert staff when the person got out of bed at night had been ordered on 9 October 2016, but we found that this was not in place. Care staff told us that the person would benefit from one to one supervision as this would reduce the frequency of their falls.

In addition, we found health and safety guidance was not always followed. An example of this was signage at the entrance to an upstairs corridor alerting staff not to block the corridor as it was a fire exit. We brought to the administrator's attention that the corridor was blocked with two wheelchairs and a mechanical hoist. This could put people at risk of harm.

Since the inspection on 9 August 2016 we noted that work to upgrade the environment had been carried out and was on-going. We also saw that there were some improvements in regard to the cleanliness of the home and infection control procedures. For example, we saw new flooring had been laid in some areas of the home. We also saw that some bathrooms, toilets and bedrooms were in the process of being redecorated and were having fittings renewed. A new dishwasher was being fitted in the kitchen during the inspection. We were told that an infestation of flies had now been eradicated.

People who lived at the home and staff had guidance on how to stay well and not acquire an infection. For example, we saw that a health education notice board had information on safe hand washing techniques, advice on receiving seasonal flu vaccinations and what to do if they had a cough. In addition, all staff were offered the flu vaccine and information was available to them about the risk of sepsis and how to identify if a person was at risk of developing this.

However, at the beginning of this inspection we noted that the central heating system was not operating and some areas of the home felt cold. We were told that the central heating system pump was broken. We found several small fan heaters placed throughout the home. There were trailing wires on the floor and there was a risk that people who lived there and staff could trip over them. We did not see any records to show that the risk had been identified or action had been taken to minimise the risk. Later in the day a member of staff checked the boiler and found that the pump had been replaced but the boiler had not been switched on again after the repair.

The upstairs sluice had four plastic urinals soaking in a plastic container in the sink. The fumes from the solution used for soaking were strong and there was no ventilation in the room. Staff could not confirm that the solution was diluted as per manufactures guidelines or that the process had been risk assessed. The door to the sluice was not locked which meant that people who lived in the home could enter the room and may be at risk from the solution fumes. We brought this to the administrators' attention.

The doors to some rooms which were either being upgraded or were used for storage of equipment were not locked. Some were propped open and there was a risk that people could enter them and come to harm from detergents, paint and maintenance equipment. We did not see any records to show that the risks had been identified or action had been taken to minimise the risk.

We found a continuing weakness in the security of the premises and there was a risk that strangers could enter the home unobserved. We identified this issue in the inspection carried out on 9 August 2016. During

this inspection we discussed the issue with the provider by telephone. The provider was aware of the risks and had plans in place to upgrade the front entrance doors and outside fencing. However, this work would take some time to complete and we did not see that any interim action had been taken to minimise the risks identified.

This was a continued breach of Regulation 12 (2) (a) (b) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 9 August 2016 we found that the provider had not ensured that people would receive their care in a safe, clean and suitably maintained environment. This was a breach of Regulation 15 (1) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 premises and equipment.

Communal areas such as the lounge, activity room, dining room and corridors were generally clean and tidy. When we were invited into people's bedrooms we saw that they too were generally clean and tidy. There was a fresh smelling atmosphere around the home. However, there were some areas of the home in which we found that a good standard of cleanliness was not adequately maintained. One example of this was in a small kitchen area people could use to make themselves drinks and snacks. We saw that the fridge seal was dirty and the inside of the fridge had spills and stains; there were stains inside the microwave and the sink surround was stained and unclean. Another example of this was in a downstairs sluice room. There was a damaged sink and floor where bacteria could breed. In the same room there was a rusted clinical waste bag holder and a mop was stored with its head down in a bucket which contained deposits of silt.

Although there were ample hand cleansing dispensers available throughout the home, some were empty or blocked. Furthermore, some hand wash sinks did not have supplies of paper towels for people who lived in the home and staff to dry their hands.

Staff were not provided with uniforms to wear and wore their own clothes. One member of care staff said, "I was told to come to work dressed smartly." Another member of staff said, "I've not had any infection control training. No one has given me advice on what to wear or shown me a uniform policy." We noted that this member of staff had polished finger nails and wore jewellery around their neck and on their wrists. Another staff member was delivering personal care wearing long sleeves. We were told that new staff uniforms were to be ordered in the near future when staff had confirmed the sizes they required.

We spoke with a housekeeper who told us that that there was not enough housekeeping staff to keep the service clean. They said, "Not enough hours. Impossible to get it all done." They did not have a cleaning schedule or checklist for the areas to be cleaned on a daily or weekly basis. However, they ensured that the sinks and toilets were cleaned every day and that bathrooms and shower rooms were cleaned two or three times a week.

This was a continued breach of Regulation 15 (1) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 9 August 2016 we found that the provider had not ensured that sufficient numbers of suitably skilled and experienced staff were employed to meet people's needs in a safe and consistent manner. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

Staff told us that they had briefly covered safeguarding training in their induction. One staff member said, "I

had a brief discussion with [the manager]. I was questioned about my knowledge, advised to escalate to management and advised not to share with anyone else." Another member of staff told us that they were aware of the signs of abuse and knew about safeguarding, but not whistleblowing and would not know what to do.

We looked at the duty rotas for November 2016 and found it was difficult to establish how many staff were on duty for each shift. This was because there were three separate rotas; one for registered nurses, one for care staff and one for support staff including the housekeeping and kitchen staff. The rotas did not record when the manager was on duty, they did not provide the full name of staff and did not record the names of agency staff on duty. This was brought to the manager's attention at our last inspection.

Care staff told us that when the clinical lead nurse was on duty they were allocated to a specific area of the home and this helped to maintain continuity of care. However, they told us when an agency nurse was in charge they were not allocated to an area and there was a risk that care may not be given in a timely way. On the day of our inspection care staff were not allocated to care for the people who lived in flats on the second floor of the home and had to decide amongst themselves who should deliver care.

The staff we spoke with told us that there were not enough care staff on duty to give the standard of care they would like to give to people. One staff member told us that it was difficult when agency nurses were on duty as they did not know the people who lived in the service and care staff had to identify people to them when they were administering medicines or tell them what people's likes and dislikes were.

We saw that people's dependency levels had been assessed and were told that the assessments were used to help determine how many staff needed to be on duty. However, when we looked at one person's records their overall dependency score was rated high and their risk of falls was assessed as high. As noted earlier in this report their need for two staff to support them with all care needs had not been met.

This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

During the inspection on 9 August 2016 we found that the provider had not ensured that quality assurance systems were reliably managed so as to enable them to identify and resolve any shortfalls in the services provided for people. This was a breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance

During this inspection we found that the provider had made some improvements to the way in which quality assurance systems were managed. Examples of this were seen in that the manager had begun to send regular reports of their medicines and risk management audits to CQC in line with the conditions applied to the provider's registration. We also found that the manager had implemented a system to identify the audits that required completion on a monthly basis. We saw audits had been carried out in relation to areas such as catering, bed mattresses, falls prevention and infection control.

However, some of the audits had not clearly identified issues which we found during this inspection. One example of this was seen in relation to infection control systems noted earlier in this report. Another example was related to the care home maintenance and environment audit carried out on 27 October 2016. This audit had not identified the issues we found regarding potential risks to people's safety and welfare from paints, detergents and maintenance equipment. In addition we saw that where audits had identified issues for improvement they did not give a clear indication of the dates by which actions should be completed or what the outcome of the actions were.

This was a continued breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had been in post since August 2016 however they had not yet registered with the Care Quality Commission (CQC).

During this inspection we found that the manager had implemented a system to improve communication between staff members. This system consisted of a handover sheet which contained a brief summary of people's needs. The nurse in charge of each shift also completed a daily summary of significant events that had occurred for each person living in the home. This meant that staff members, including those who were employed through an agency, had a clear overview of each person's up to date support needs. The manager had also implemented a comments book regarding the provision of meals. However we found that only those people who were able to verbalise their views and record them were able to access the book.

We found there were no systems in place to effectively support people who did not speak English as their first language or had difficulty vocalising their needs. One person who could not vocalise their needs made hand gestures towards an inspector who was not able to interpret their communication. A member of staff was asked to assist, however they told us that they were not "very good" at understanding the person's communication. We saw information leaflets on how to achieve and maintain a healthy lifestyle were only written in English. We saw no evidence that they were available in other languages, or in an easy read or

picture format. Care staff told us that they had not received training on how to meet people's diverse communication needs. One member of staff said, "[Person] has signs they make to communicate, like pulling on their ear, but I don't know what they mean. They don't have any picture cards or anything like that."

We looked at the communication care plans, hospital passports and emergency grab sheets for three people who did not speak English as their first language. Although there were some indicators in the care plans on how to communicate with people we found this did not happen in practice. For example, one person's care plan advised that a computer based translation was used, however care staff were not aware of this and had not seen it used. Another care plan advised to use an interpreter but this had not been actioned. Furthermore, we found that hospital passports that could provide essential information to hospital staff about a person's care needs were left blank. The care practices were in contrast to people's care plans that identified the risk of social isolation due to the lack of effective and meaningful communication.

During this inspection we found that staff members did not feel supported by the management arrangements within the home. One member of staff told us they felt the manager was unapproachable and they felt unable to share concerns with them. Another member of staff said, "I have been chucked in at the deep end. I feel I'm in the way. I never get feedback on my role." Other members of staff told us that they worked on their own initiative and without supervision from more experienced staff.

We looked at the induction records for two staff members and saw that although it was recorded that they would have a mentor to support them through their induction and probationary period this had not happened. Some staff told us that their induction was poor and they were not prepared for their role. One staff member said, "My induction was poor. I had no shadowing. [The manager] was on leave. After two weeks the manager returned and I was shown how to safely move and handle people." One staff member told us they had received supervision from the provider's area manager and occasionally had a team meeting to discuss how they could improve the environment. Other members of staff told us that they had not been invited to attend team meetings since June 2016. One staff member said, "We have to support each other. There is no team sharing or team building."