Blake Court Limited

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Inspection report

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Date of inspection visit:
16 March 2021

Date of publication:
06 May 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Blake Court Limited operates and manages residential retirement homes for older people wishing to maintain their independence without having to move into a residential or nursing home setting. People have access to extra care services where there is an identified need. Blake Court has 71 flats and is part of a gated community in North London. At the time of this inspection five people were receiving the regulated activity of personal care.

People's experience of using this service and what we found
One person and relatives were happy with the care they and their family member received and spoke highly of the registered manager, duty managers and housekeeping assistants. However, despite the positive feedback we identified issues and concerns around staff recruitment processes, risk management, medicines management and management oversight.

Identified risks associated with people's health and care needs were not always comprehensively assessed and documented. This meant that care staff, referred to as housekeeping assistants, did not have available clear and detailed information on how to minimise risk potentially placing people at risk of harm.

Staff recruitment checks were not robust and did not always provide assurance that staff employed had been appropriately assessed as safe to work with vulnerable adults.

Managerial oversight of the service was ineffective and did not identify the issues we found as part of this inspection. A number of policies and procedures had not been reviewed since 2017 which meant that staff did not have access to current guidance and process.

Records confirmed that people received their medicines safely and as prescribed. However, minor issues identified with medicines management and an out of date medicines policy meant that people may be placed at the risk of receiving their medicines unsafely.

Housekeeping assistants understood safeguarding and how to keep people safe from abuse. Staff told us that they received training to support them in their role.

Relatives feedback about the registered manager and the way in which Blake Court was managed was positive stating that housekeeping assistants were kind, caring and approachable.

Communication between people, relatives and the service was very good. People and relatives were regularly updated about the service and relevant changes.

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 good (published 24 May 2017).

Why we inspected
We carried out an announced comprehensive inspection of this service on 19 April 2017. The service was rated good at that time. Due to the length of time since the last inspection, we undertook this focused inspection to check and confirm that the service continued to meet legal requirements.

We reviewed the key questions of safe, caring and well-led only to check and ensure people were receiving safe, good quality care.

During the inspection we identified concerns around risk management, recruitment, medicines management and management oversight processes. 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 requires improvement. This is based on the findings at this inspection. Please see the safe and well-led sections of this full report.

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 Blake Court on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Blake Court Limited

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
This inspection was carried out by three inspectors. Two inspectors visited the office and the third inspector completed inspection activity by e-mail and phone.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought and is the occupant's own home. People's care is provided under a separate contractual agreement. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service short notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 16 March 2021 and ended on 29 March 2021. We visited the office location on 16 March 2021. Following the on-site inspection, we completed the inspection via phone and e-mail. On 17 and 18 March 2021 telephone calls were made to people, relatives and staff to gain their feedback.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and formal

notifications that the service had sent to the CQC. Notifications are information that registered persons are required to tell us about by law that may affect people's health and wellbeing.

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 used all of this information to plan our inspection.

During the inspection
During the office visit, we spoke with the registered manager. We reviewed five staff recruitment records, one person's care plans and risk assessments and two people's medicines records. We also reviewed accident/incident records and certain health and safety documents.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures, quality assurance information and training information. We spoke with one person, four relatives and five care staff who are known as housekeeping assistants.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Recruitment checks and processes were not always fully completed to ensure that staff recruited had been assessed as safe to work with vulnerable adults.

● For two staff members who had been recruited, information about their conduct in previous known employment had not been requested and obtained. For other recruitment files there was insufficient evidence available of conduct in previous employment. References not been obtained from places of work listed on the application form that were associated with care.

● Application forms were not fully completed, dated or signed. Full employment histories were not always obtained, and referee details did not always include contact details for the last known place of work for the applicant especially where the place of employment was related to care.

● This meant that staff had not been adequately assessed to confirm good character and safety to work with vulnerable adults.

We found no evidence that people had been harmed however processes and checks were either not in place or comprehensively completed to ensure safe staff recruitment. This placed people at the risk of potential harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment checks including Disclosure and Barring Service check (DBS) and proof of identification had been completed. DBS checks informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults.

● One person and relatives confirmed that they were supported by a regular team of housekeeping assistants who they had built positive relationships with.

● Where there were any changes to timings of support calls or the housekeeping assistant who was due to the support them, people were always informed of the change by the duty manager. One person told us, "More often than not they always come but if they are going to be late or they can't come I get a phone call."

Assessing risk, safety monitoring and management

● Risks associated with people's health and care needs were not always assessed and recorded within their care plan. For example, one person had been prescribed a blood thinning medicine which placed the person at risk of bruising or bleeding. This had not been risk assessed. Another person was at high risk of falls. This had not been risk assessed so that housekeeping assistants had clear guidance on how to manage this risk and ensure the person's safety.

● Risks assessments assessed risks associated with being unsteady when mobilising, incontinence, nutrition

and mobility. However, where risk assessments were in place, these were basic and lacked guidance for staff on how to manage the known risks.
● People currently receiving care and support had low risk assessed needs and whilst we found there was no evidence that people had been directly harmed by the issues as identified above, risks associated with people's health, medical and care needs were not comprehensively assessed and recorded.
● The registered manager, duty managers and housekeeping assistants demonstrated a clear understanding of people's risks and actions to take to minimise the risk of harm. Relatives also confirmed that staff knew people well and understood their care needs. One relative told us, "They [housekeeping assistants] know about his risks."

Using medicines safely
● People received their medicines safely and as prescribed. Medicine Administration Records (MARs) were seen to be complete and no gaps or omissions in recording were identified.
● Relatives confirmed that they had no concerns with the support their relative received with medicines. One relative told us, "I had massive concerns when he was managing himself and the service was worried as well. The service has now been administering his medicines for two months."
● However, during the inspection we identified minor issues with the overall management of medicines. The providers policy, written in April 2017 had not been reviewed or updated in line with national guidance.
● Care plans did not clearly document the type of support people required with medicines and did not detail the current list of medicines prescribed.
● One person had been prescribed a medicine which had to be administered in a specific way. The person had refused to comply with the specific direction and advice had been sought from the pharmacist. However, the advice and guidance received had not been clearly documented within the person's care plan around how staff were to continue supporting the person with safe medicine administration.
● All staff had received medication training and had their competency assessed before administering medication. However, competency assessments had not been reviewed annually in line with national guidance.
● Medicine audits were completed every six months to ensure people were receiving their medicines safely and as prescribed. However, these audits did not identify the issues we identified as part of this inspection. This has been reported on further under the well-led section of this report.

We found no evidence that people had been harmed however, systems were not in place to ensure risks associated with people's health and care needs and been comprehensively assessed. Systems were also either not in place or robust enough to ensure safe medicine management and administration. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● One person and relatives confirmed that they felt safe and assured with the care and support that they and their family member received at Blake Court.
● One person told us, "I definitely feel safe. A couple of years ago I fell on the floor whilst going to bathroom and I have a pendent which I pressed and someone came up to help me, they called an ambulance straight away." A relative said, "Yes I am assured she is safe, she has an alarm button and call bell which she can use and they are always very responsive."
● Staff had received training in safeguarding which was regularly refreshed.
● Staff understood their responsibilities around safeguarding and understood how to report any concerns.
● The registered manager and duty manager were clear of their responsibilities in relation to reporting and investigating safeguarding concerns where required.

● Whilst we were assured staff understood safeguarding and how to keep people safe, the safeguarding policy, written in 2017, had not been reviewed or updated in line with current national guidance. This is discussed in the well-led section of this report.

Preventing and controlling infection

● People were protected by the safe use of infection control practices.

● An increase in daily cleaning had been implemented around the schemes during the pandemic to prevent cross-infection.

● People were provided with information and regular updates in relation to the COVID-19 pandemic which included steps the service had introduced during this time to keep people safe.

● Personal Protective Equipment (PPE), in line with government guidance, was available for housekeeping assistants to wear when delivering personal care and supporting people. Staff had received training on infection prevention and control and the effective use of PPE.

● However, we did identify that the provider's infection control policy written in April 2017 had not been reviewed or updated since then especially in light of the current on-going pandemic. This has been further reported on under the well-led section of this report.

Learning lessons when things go wrong

● The service monitored accidents and incidents to ensure lessons were learnt to prevent future re-occurrences and keep people safe.

● Accidents and incidents were documented and included details of the event and actions taken at the time.

● The registered manager explained that all accidents and incidents were reviewed and discussed at daily handovers and team meetings with duty managers and housekeeping assistants so that learning and development could be shared.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- One person and relatives told us they were very happy with the care and support that they received. One person and relatives explained that housekeeping assistants were kind and caring and went above and beyond to support people.
- One person explained, "Very pleased with the service. It sounds like a simple thing that they [housekeeping assistants] do but it makes my day. To be honest they are more like friends. They are friendly girls and you get to know them and sometimes we have a little giggle and a laugh."
- Relatives feedback included, "Housekeeping assistants have the personal touch, the fact that I actually feel they care for my mum as if my mum was their mum too, that means a lot" and "They [housekeeping assistants] do really care about the residents, they are treated very very well and they do take an interest in people."
- Housekeeping assistants explained how they had established positive and caring relationships with people they supported which enabled them to deliver good person centred care. One housekeeping assistant explained, "I think I am quite a friendly person myself which helps put people at ease, kindness, reliability, if you do things well, you are doing job well. We become friends. You just can't be a carer by name, you have to be of a caring nature. I am a caring person. I treat people like I want to be treated."
- People's diverse needs, as defined under the Equalities Act 2000, were respected. For example, people's needs related to their relationships and religion had been documented in their care plan.

Supporting people to express their views and be involved in making decisions about their care

- Care plans documented people's needs, preferences, likes and dislikes on how they wished to be supported.
- One person and relatives confirmed that they had been involved in decisions made about their care provision. One relative told us, "We have been involved and we have been asked to make an appointment to go through the care plan, we tweak what we want."
- Housekeeping assistants explained how they delivered care with a person-centred approach. One housekeeping assistant stated, "It's all about the individual."
- Prior to the COVID-19 pandemic, people were encouraged and supported to attend monthly owners meetings where they had the opportunity to express their views and opinions on how the service was run and managed. However, due to the pandemic, in the absence of these meetings, monthly newsletters were sent to owners providing updates and information about the management of the service.

Respecting and promoting people's privacy, dignity and independence

● One person and relatives described housekeeping assistants as being "consistent", "affectionate", "caring", "helpful" and "kind."
● One person and relatives told us that housekeeping assistants were always respectful and that they were supported in ways which respected their privacy and dignity. One person said, "They [housekeeping assistants] never take liberties."
● Housekeeping assistants described various ways in which they respected people's privacy and upheld their dignity. One housekeeping assistant explained, "When a person goes to the toilet, I make sure the door is closed, when I help shower people, I always cover them up, hold the towel up to respect their dignity."
● Housekeeping assistants explained how they encouraged people to do as much for themselves where possible. One housekeeping assistant said, "I ask them and get them to try and do things, encourage them, not just go in and do it for them, encourage them to go for a walk."

Requires Improvement

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 requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager, duty managers and housekeeping assistants were clear about their roles and demonstrated a clear of understanding of delivering good quality care. However, the provider and registered manager had not given full consideration towards meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Policies and procedures that we reviewed as part of the inspection process which included safeguarding, medicine and infection control policies had not been reviewed or updated since 2017. This meant that information and guidance contained within the policies was not up to date and reflective of current national guidance and directives.
- Risk assessments lacked detail about people's individualised risk and where certain risks placed people at the risk of harm, these had not been assessed and documented.
- Recruitment checks were not always robustly completed which meant that staff were not always comprehensively assessed as safe to work with vulnerable adults.
- We identified issues with the management of medicines, where care records lacked detail around the ways in which people were to be supported with medicine administration and medicine administration practices were not in line with current national guidance.
- Whilst the registered manager and duty managers carried out checks. reviews and audits of medicines management, care plans and health and safety, these audits were basic. Audits completed were a tick box exercise which did not look at the areas being audited in detail and therefore had not identified any of the issues we found as part of the inspection process.

Whilst we found there was no evidence that people had been directly harmed by the issues as identified above, systems were either not in place or robust enough to demonstrate that there was adequate oversight of the home. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- One person and relatives spoke positively of the registered manager, duty managers and housekeeping assistants, stating that the service was managed well and delivered good quality care and support as required. One relative told us, "[Registered manager] is very accessible, I am assured. The whole team is very

helpful. They go above and beyond to check up on [person]."
● One person and relatives also told us that they knew the housekeeping assistants, duty managers and the registered manager very well and were confident in approaching them when required with their concerns which were addressed immediately. One relative stated, "I feel so confident in the staff, they love my mum, I feel the affection they show for her."
● Relatives and one person confirmed that they had all been involved in the care planning and review process. Communication books in place for each person enabled effective communication and information exchange between staff and relatives so that they were kept abreast of people's care delivery and needs.
● Regular telephone and written contact had also been maintained, especially during the COVID-19 pandemic to provide relevant updates. Relatives told us, "Communication with residents is very good in the form of newsletters" and "Communication is good. We get an email or telephone call. There is also a communication book in the flat."
● Staff spoke positively about the registered manager and the duty managers and stated that they were well supported, offered continuous training and development and were able to approach any of the managers at any time with their concerns.

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; Continuous learning and improving care;
● The registered manager clearly understood their legal responsibilities in relation to being open and honest with people when something went wrong. Relatives confirmed that communication between them and the service was very effective and that they were always kept updated about the health and well-being of their family member.
● Where required, the registered manager and duty manager were aware of their responsibility of informing the CQC and other involved agencies where specific incidents had taken place or allegations of abuse had been made.
● Throughout the inspection the registered manager demonstrated a willingness to learn and reflect to improve the service people received. This gave reassurance that the service acknowledged our feedback and was open and willing to continuously learn, develop and improve the quality of care provided.
● The registered manager explained that learning was always encouraged within the team. Where accidents/incidents had occurred, or complaints or safeguarding concerns had been raised these were discussed at daily handovers and team meetings so that improvements and development could be discussed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● One person, relatives and staff told us that they were engaged and involved in the planning and delivery of care as well as the day to day running and management of the service.
● People known as owners were able to contribute and engage with management through monthly owner meetings as well as scheduled manager surgeries giving them the opportunity to give their views and opinions on how Blake Court was run and managed.
● People and relatives were also asked to complete satisfaction surveys and the last survey was completed in October 2020. Feedback was positive. Where issues and concerns were identified these were addressed individually with the person and/or their relative.
● Housekeeping assistants also told us that they were always encouraged to engage and be involved in the management of the service. This was facilitated through supervisions, annual appraisals and monthly staff meetings.
● We saw that the service worked in partnership with external agencies such as GP's and district nurses to maintain the health and wellbeing of 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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's health and care needs and not always been assessed. Where risk assessments were in place these lacked detail and failed to provide staff with adequate guidance to minimise the risk. There were ineffective systems in place to manage medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems and processes in place to assess, monitor and improve the quality of the services provided.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to operate effective recruitment procedures to ensure that persons employed meet the conditions as specified in Schedule 3.