Bluewater Care Homes Limited

Bluewater Nursing Home

Inspection report

143-147 Kingston Road
Portsmouth
Hampshire
PO2 7EB

Tel: 02392008855

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28 July 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 28 July 2017 and was unannounced. This was a focused inspection to review the actions taken by the provider following our previous inspection in October 2016 when we identified that improvements were required. This means not all aspects of the service were assessed and therefore the quality ratings for the service were not been reassessed. This will be undertaken at the next comprehensive inspection.

The home provides accommodation for up to 60 older people with personal care needs. There were 15 people living at the home when we visited. All areas of the home were accessible via a lift and there were communal rooms and areas on the ground floor and adjacent to people's bedrooms. There was accessible outdoor space from the ground floor. All bedrooms were for used for single occupancy and had en-suite facilities.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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 had submitted an application to the commission to become the home's registered manager.

The provider had taken appropriate action to address the concerns identified at previous inspections. People's legal rights were protected and the provider's systems to support this were in accordance with the Mental Capacity Act 2005. People received care that was personalised to meet their individual needs. Care plans and individual risk assessments were comprehensive and reviewed regularly to help ensure they reflected people's needs. These and other records related to the care people had received were well maintained and up to date.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

People's legal rights were protected and the provider's systems to support this were in accordance with the Mental Capacity Act 2005.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

Records relating to people's care were up to date, consistent and reflected the care people were receiving.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Bluewater Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection which took place on 28 July 2017 and was completed by two inspectors and was unannounced. This was a focused inspection to review the actions taken by the provider following our previous inspection in October 2016. This means not all aspects of the service were assessed and therefore the quality ratings for the service have not been reassessed. This will be undertaken at the next comprehensive inspection.

Before the inspection we reviewed previous inspection reports, action plans and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with 11 people living at the home. We also spoke with the manager and two care staff. We looked at care plans and associated records for four people and records relating to the management of the service.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in October 2016 we found the providers systems did not ensure people's legal rights were protected in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to ensure people's rights to consent to care and support were upheld. At this inspection we found improvements had been made and people's legal rights were protected.

People told us they were able to make decisions and their views were respected. People told us they were able to spend time where they wished and were not expected to do anything they did not wish to do. One person told us that if they told care staff they were not ready to get up then staff would return later to support them. At lunch time we saw people had various meals. They told us this was their choice and they were always asked what they wanted. We saw people were offered choices of drinks at lunch time and some people had chosen to have their meals in the dining room and others in their bedroom.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people living at Bluewater Nursing Home had a cognitive impairment and were not able to give valid consent to certain decisions including the delivery of personal care, the administration of medicines and the use of photography and CCTV. Where necessary care records contained specific assessments of the person's ability to make these individual decisions as required under the MCA. Where these assessments identified that people lacked the capacity to make a specific decision best interests decisions were made on behalf of people in consultation with family members. Some relatives had informed the home they had the legal power to make decisions on behalf of people, such as under lasting powers of attorney. A copy of this was obtained by the manager to confirm which relatives could legally make decisions about health and care for people.

The manager had arranged training for staff in relation to the MCA. They told us they had also completed this training which they felt had been interesting and informative. Care staff had also undertaken training in dementia awareness which included supporting people to make decisions. Care staff told us how they offered choices and sought consent before providing care. One said, "If they said no, we try later, or someone else [staff] would try. If that didn't work we would tell the senior."

The provider was no longer in breach of Regulation 11 (need for consent). The provider has taken appropriate action to ensure that people's legal rights under the Mental Capacity Act 2005 to make decisions or where necessary for relevant people to make decisions on their behalf will be upheld.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in April 2016 we found the provider had failed to make sure that the care planning process had resulted in care and support that met people's needs and took account of their preferences. At the last inspection in October 2016 we found that sufficient action had not been taken and the care planning systems did not ensure that people received all the health and care support they required. This was a continuing breach of Regulation 9 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to ensure the care planning process ensured people's preferences and care needs were met. At this inspection we found improvements had been made and people were receiving the consistent individual care they required.

People, and when appropriate relatives, were involved in care planning and reviews of care. People were aware they had a care plan. Most people said they were not interested in reading this but were sure they could do so if they wanted to. We saw some people had signed their care plans and where appropriate relatives had signed other people's care plans. This demonstrated that people or relevant others had been included in the care planning process.

A computer based system of care planning was in use. People's care planning was organised according to aspects of their personal care needs such as communication, mobility, emotional support, medical and personal care needs. Each care plan contained an assessment of the person's care needs and actions which were required to meet these. Care staff had hand-held devices which reminded them when specific tasks such as repositioning were due and enabled staff to record when this had been completed. The system also alerted the manager when care plan reviews were due or if care staff had not completed essential tasks within a prescribed time scale.

Care plans were centred on the individual, considered aspects of their individual circumstances and reflected their needs and preferences. Care plans provided comprehensive information about how people wished to receive care and support. Individual care plans were well organised and the guidance and information for staff within them was individualised and detailed. For example, one care plan included information about topics of conversation the person was interested in talking about. Care plans also included specific individual information to ensure medical needs were responded to in a timely way. For example, a care plan contained specific guidance as to how often a person who had diabetes should be supported. Another care plan included specific details about how the person should be supported when moving between their bed and chairs and around the home. Daily records of care provided corresponded to information in care plans demonstrating that people were receiving the care they required. Care plans and related risk assessments had been reviewed monthly and amended when required to ensure the information continued to reflect people's needs. This helped ensure care plans continued to reflect how people were being cared for.

The provider was no longer in breach of Regulation 9 (Person-centred care). The provider has therefore taken appropriate action to ensure that people received individualised care and support to meet their assessed and planned care needs.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in April 2016 we found the provider had failed to ensure that accurate and up to date records of people's care were maintained. At the last inspection in October 2016 we found that whilst some improvements had been made these had not been sufficient to ensure that people's care records including care plans were always complete, up to date and consistent. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to ensure care records were well maintained and up to date. At this inspection we found improvements had been made.

We viewed care plans and records of care people had received and records relating to medicines administration for four people. We found these were more organised than previously and provided appropriate detailed consistent information about people's needs and how these should be met. The manager was able to provide all records we requested and told us they reviewed all care plans at least monthly and when needs changed to ensure these continued to reflect people's needs.

The provider was no longer in breach of Regulation 17(Good Governance). The provider has therefore taken appropriate action to ensure that records relating to people's care were up to date, consistent and reflected the care people were receiving.