Bluebell Nottingham Ltd

Bluebell Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an unannounced inspection at Bluebell Lodge on 6 March 2018. Bluebell Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bluebell Lodge accommodates up to 36 people in one building. On the day of our inspection, 30 people were living at the home, all of these were older people, some of whom were living with dementia. This was the first time we had inspected the service since they registered with us.

There was a registered manager in post at the time of our inspection. 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.

During this inspection, we found the service was not consistently safe. People were not always protected from risks associated their care and support. People were at risk of choking as staff did not following guidance to reduce the risk. We also found inconsistent practice related to the management of risks associated with falls and with people's behaviour. There were not always enough staff available and staff were not deployed effectively to meet people's needs and ensure their safety. This placed people at risk of harm.

People told us they felt safe and there were systems and processes in place to minimise the risk of abuse. Safe recruitment practices were followed to ensure staff were suitable to provide support. Medicines were stored and managed safely and records showed people received their medicines as required. The environment was clean and hygienic; however, improvements were needed to ensure the cleanliness of equipment used in people's care and support.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Systems in place to protect people from risks associated with eating and drinking were not always effective. We received mixed feedback about the food. People were supported to attend health appointments. However, there was a risk people may not receive appropriate support with specific health conditions. This was because care plans did not consistently contain sufficient information for staff to follow and staff did not always have adequate knowledge of people's health conditions. Overall though, we found people were supported by staff that had the skills and knowledge to provide good quality care and support. There were systems in place to ensure information was shared across services when people moved between them. The design and decoration of the building accommodated people's diverse needs.

People told us they were involved in decisions about their care and support; however, we found this was not always the case. We observed some occasions where staff made decisions on people's behalf without consulting them. People's right to privacy was not always respected and they were not always treated with

dignity. Despite this, people told us staff were kind and caring. People had access to advocacy services if they required this.

People were at risk of receiving inconsistent support, as care plans did not all contain accurate, up to date information and staff did not always follow the guidance in care plans. People were provided with some opportunities for social and recreational activity, However, we observed opportunities for meaningful activities were missed and activities did not meet the needs of all people living at the home. People's friends and family were welcomed into the home and were involved in the care and support of their loved ones. People were provided with an opportunity to discuss their end of life wishes and this was compassionately recorded in people's care plans. There were effective systems in place to investigate and respond to concerns and complaints.

There were no formal systems in place to identify and address issues with the day to day practice of staff, consequently some poor practices had developed which impacted negatively on people living at the home. Staff did not have adequate access to IT systems that meant they were unable to keep up to date records of the care they provided to people. There were systems in place to monitor and improve the quality and safety and to analyse and learn from adverse incidents. However, improvements were required to monitor the practice of staff more effectively. Staff and people living at the home were able to express their views in relation to how the service was run and this was used to inform improvement. Staff and people who used the service were positive about the registered manager and felt supported. The management team were responsive to our feedback and developed an action plan in response to the concerns identified during this inspection.

During this inspection, we found two breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always protected from risks associated their care and support.

There were not always enough staff and staff were not deployed effectively to meet people's needs and ensure their safety.

There were systems and processes in place to minimise the risk of abuse. Safe recruitment practices were followed.

The environment was clean and hygienic, however improvements were needed to ensure the cleanliness of equipment used in peoples care and support.

Medicines were stored and managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

Systems in place to protect people from risks associated with eating and drinking were not always effective. We received mixed feedback about the food.

People were supported to attend health appointments. However, there was a risk people may not receive appropriate support with specific health conditions.

People were supported by staff who received training and support.

The environment was adapted to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to privacy was not always respected and they were not always treated with dignity.

People were not always involved in decisions that affected them.

People were supported to be as independent as possible.

Staff were kind and caring, had an understanding of what was important to people and how to communicate with them.

People had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be assured that they would receive the support they required as care plans did not all contain accurate, up to date information about the support people needed. Staff did not routinely use care plans to inform care and support.

People were provided with some opportunity for meaningful activity. Further improvements were needed to ensure activities catered to a wider range of people.

People were given the opportunity to discuss their end of life wishes.

People were supported to raise issues and concerns and there were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were systems in place to monitor and improve the quality and safety. However, improvements were required to monitor the practice of staff more effectively.

Accurate and up to date records were not kept of people's care and support.

Staff and people living at the home were able to express their views in relation to how the service was run and this was used to inform improvement.

The management team were responsive to our feedback and developed an action plan in response to the concerns identified during this inspection.

Bluebell Lodge

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, to look at concerns we received about the quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was prompted, in part, by notification of an incident following which a person died. This incident is subject to a coroner's inquest and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. During our inspection visit we spoke with 10 people who lived at the home and three people's relatives. We also spoke with seven members of care staff, a member of the catering team, the activity coordinator, the deputy manager and the registered manager. In addition, we spoke with one external health professional during our inspection visit.

To help us assess how people's care needs were being met we reviewed all, or part of, seven people's care records and other information, for example their risk assessments. We also looked at the medicines records

of four people, five staff recruitment files, training records and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

We asked the registered manager to send us a copy of their training record and various policies and procedures, which they did prior to this report being completed.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's care and support were not always managed safely. Although risks had been assessed, staff did not always use this information to inform their support and we found some care plans required more detail to ensure staff had access to detailed information about risk management.

People were not protected from the risk of choking. One person's care plan stated they were at risk of choking and detailed measures to reduce the risk of choking. However, we saw staff did not follow the guidance to ensure their supervision when eating. The person was left alone in their room to eat their meal and we observed them to be coughing whilst eating. There were no staff present which meant, had the person choked, staff would not have been aware of this and consequently would not have been able to respond swiftly to provide emergency first aid. Another person started coughing and choking while being assisted to eat by a member of staff. We intervened to find a second member of staff to assist. The deputy manager attended and advised the member of staff of specific support the person required to prevent choking. The staff member was not aware of this before providing support and this exposed the person to the risk of choking and consequent harm. Following our inspection the registered manager assured us that immediate action had been taken to ensure people's safety and other improvements were planned.

People were not always protected from the risk of falls. One person had been identified as being at high risk of falls and consequently had a motion sensor mat in their room to alert staff to their movement. However, during our inspection the person was in bed and the motion sensor mat was not plugged in which meant staff would not be alerted to the person's movements and may miss opportunities to prevent a fall. This placed the person at risk of harm.

In addition to the above, the environment increased the risk of people falling. There were two raised areas of flooring in the main communal corridors. These had been covered with hazard tape but there was still a risk that people may trip over them. The registered manager told us they had been caused by raised drainage works, they said they would explore what else could be done to reduce the risk.

There was a risk that people may not receive the support they required in relation to their behaviour. Care plans did not always contain a sufficient level of detail to inform staff support. One person frequently behaved in a way that put others at risk. Although their care plan contained information about the behaviours and potential triggers, it did not contain clear information about how to minimise the risk or what staff should do should the person's behaviour escalate. During our inspection, we saw that staff did not have an adequate understanding of how to reduce this risk and consequently this placed other people at risk of harm.

Risks associated with bedrails were not effectively assessed. One person had gaps at the top and bottom of their bedrail, which posed a risk that they may become entrapped. This risk was not identified in the bedrail risk assessment, and subsequently had not been mitigated. This increased the risk of entrapment or the person trying to get out of bed through the gap and placed them at risk of harm.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas care plans and risk assessments contained information about the actions in place to reduce the risk to people. For example, when people were at risk of skin damage we saw pressure relieving equipment appropriate to the person's level of risk were in place and records showed they were being assisted to move their position regularly.

There were not always enough staff available to meet people's needs and ensure their safety. Feedback about staffing levels was varied. Although most people felt there were enough staff to keep them safe they commented that staff were often very busy and there were certain times, such as nights, where staff were not as readily available. One person told us, "I would say they have enough staff there is always someone here to help if you need them." Another person said, "I think there are enough staff, but it depends on needs. Some people in here need a lot of help, but if the staff know you are in need of help they help you." In contrast a third person commented, "I don't think there are enough staff on at night time I don't think there are many." Another person said, "I think they could do with more staff to relieve the pressure they try very hard and have lots of patience."

Staff feedback about staffing levels was also mixed. One member of staff told us, "No there are not enough staff…There are times when it is not safe as people are left on their own with no staff supervision." Another member of staff commented, "There have been times when there have not been enough staff at weekends and three (staff members) is not enough to keep people safe."
Throughout our inspection we saw instances where poor staff deployment placed people at risk of harm. For example, there had been a recent incident between two people living at the home and staff told us, that consequently these two people were "kept away" from each other. Despite this, we saw these two people together in communal areas, on multiple occasions, with no staff supervision. On one occasion one person held on to the others arm, the situation diffused before we needed to intervene, however this was a risk. On another occasion we saw approximately 15 people, including some people who were at risk of falls and some whose behaviour posed a risk to others, were left in a communal area unattended for a period of around five minutes. This placed people at risk of harm. This failure to ensure the effective deployment of staff placed people at risk of harm. We reviewed rotas and found there were times when there had only been three staff on shift. This was below the level, which the provider had determined as safe and placed people at risk of harm. We discussed staffing levels and deployment with the registered manager who told us staffing levels had been affected by changes in the staff team and poor weather conditions. Following our inspection the registered manager assured us that immediate action had been taken to ensure people's safety and other improvements were planned.

The above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal records checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

People told us they felt safe at Bluebell Lodge. One person told us, "I feel safe because I am always amongst people. It's solitude I don't like." Another person commented, "They (staff) come around at night, they walk up and down the corridors, and I leave my door open at night. The staff walking up and down the corridors puts my mind at rest." People also told us about practical things which made them feel safe including call

bells and security measures, such as the front door being locked. Three people told us that although they felt safe most of the time, people sometimes wandered into their rooms uninvited and this made them feel unsafe. One person told us, "Staff come in to my room but I don't feel safe with others (people who live at the home) coming in." We discussed this is with the registered manager who told us they would address this by working with senior care staff to improve the deployment of staff.

Processes were in place to minimise the risk of people experiencing avoidable harm or abuse. Staff and managers were clear about their responsibilities to protect people from the potential risk of abuse and felt confident any issues they reported would be acted on appropriately. The registered manager had taken action to protect people from abuse by conducting investigations of any concerns raised and making appropriate referrals to the local authority safeguarding adults team. Some staff were not aware of external organisations who could be contacted about safeguarding concerns. We shared this feedback with the registered manager who told us they would address this with the staff team.

There were systems in place to review and learn from adverse incidents. The registered manager reviewed and responded to each incident to try to prevent the same from happening again. There was also a system in place to analyse and learn from patterns of incidents on a monthly basis.

People received their medicines as required. People told us they got their medicines when they needed them. Medicines systems were well organised and medicines records were completed accurately to demonstrate that people had been given their medicines as prescribed. However, where people were prescribed medicines to be used 'as needed' there were not protocols in place to guide their use. Despite this, staff demonstrated a good understanding of when these medicines should be administered and records showed people got them as required. We also found that where people were prescribed medicated skin patches guidance was not followed to prevent skin irritation. We shared these concerns with the deputy manager and the registered manager who informed us they would take action to address this.

People could not be assured that good hygiene practices were followed. Although we found, overall, the environment was clean and hygienic, effective cleaning procedures were not in place for some items of equipment used in people's care and support. We saw staff using communal wheel chairs during our inspection visit, these were not routinely cleaned between different people using them. We observed mobility equipment such as hoists and wheelchairs were not clean. Some hoists were sticky and dusty and some wheelchairs were stained. There were no effective systems in place to ensure the proper cleaning of equipment. This was an unhygienic practice which meant that people were potentially using equipment which was not clean. In addition, we saw the surface of the foam covers for bed rails were damaged, increasing the infection prevention and control risk. We discussed this with the registered manager who told us they would address this.

In other areas we found staff had access to plentiful supplies of personal protective equipment, such as gloves and aprons, to ensure good infection control practices. Records showed the majority of staff had up to date training in the prevention and control of infection. A team of domestic staff took responsibility of the cleanliness of the environment and the registered manager completed regular audits of the environment to identify issues and ensure good practice.

People were protected from risks associated with the environment. We saw there were systems in place to assess and ensure the safety of the service in areas such as fire and legionella. There were personal evacuation plans in place detailing how each person would need to be supported in the event of an emergency such as a fire. Staff had been trained in health and safety and food hygiene.

Requires Improvement

Is the service effective?

Our findings

People were not protected from risks associated with eating and drinking. Although nutritional risk assessments and care plans were in place and catering staff had knowledge of people's needs, this was not always put into practice. For example, one person needed thickened fluid to reduce the risk of choking but we saw this was not always provided. Another person needed food of a soft texture, however we saw on two occasions they were served hard foods which put them at risk of choking. This did not meet people's needs and placed them at risk of harm. Following our inspection the registered manager assured us that immediate action had been taken to ensure people's safety and other improvements were planned.

There was a risk people may not be protected from the risk of unplanned weight loss. Systems in place to monitor people's weight were not always effective. For example, one person's care plan stated they had not lost weight within the last three months, however weight records showed they had not been weighed in the past three months. This meant the assessments may not have been completely accurate. Another person had been identified as being at risk of weight loss but we noted they had not been weighed for a period of six months. Although their most recent weight showed they had not lost weight this failure to regularly monitor people's weight put them at risk. Following our inspection the registered manager told us they would address this with the senior care staff.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and their relatives gave mixed feedback about the food served at Bluebell Lodge. One person told us, "The food is okay I grin and bear it, I have my own food too, my family bring in sweet things for me." Another person said, "I only come down for lunch and breakfast, I do not eat the tea. The sandwiches I think they use frozen bread and eating them is like having a mouth full of dough." A relative told us, "I think [relation] gets enough to eat and drink when I ask they always say they have enjoyed it." Another relative explained they brought food in for their relation as they did not feel confident the home would cater for their specific preferences, they told us, "It's not that sort of place".

During our inspection we observed a meal time and saw people were offered a choice of two adequately sized portions of home cooked food. One person did not want what was served, they were offered alternative meals until they found something they wanted. People were provided with timely assistance when needed. People's cultural needs were catered for and there were cold and hot drinks available throughout the day.
People were not always involved in decisions about food and mealtimes. There was not enough room in the dining room for everyone to sit at a dining table so many most people remained in their lounge chairs. We observed these people were not offered a choice about where they sat. There was a four week rotational menu. The provider had determined this and people had not been consulted about this prior to its implementation. The registered manager told us they discussed the menu at residents meetings and gave feedback to the provider. However, the catering staff said they did not have contact with the provider and therefore it was difficult for them to make suggestions or request additional items. However, catering staff

told us they tried as far as possible to make sure people had something they liked.

The Mental Capacity Act (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 made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected as the Act had not always been correctly applied to ensure decisions were made in people's best interests. Mental capacity assessments had not been completed in all required areas. People's capacity to consent to restrictions on their freedom had not been formally assessed, such as, the use of bedrails and motion sensors. In addition, CCTV was used throughout communal areas of the home. Although a letter had been sent to people's families about this, people's rights under the under the MCA had not been considered and consequently there was no evidence that the use of CCTV in communal areas was in their best interests. Care records contained conflicting information about people's capacity. For example, a person's recent assessment documentation stated they had capacity to consent to their care and treatment, but we saw a Deprivation of Liberty Safeguard (DoLS) had been authorised for them. DoLS are only authorised for people who lack capacity.

The provider had sought consent from people's relatives where they did not have the legal authority to do so. People's care plans recorded that relatives had provided 'consent' to the use of photographs. However, there was no indication that these relative had any legal powers, such as a Health and Welfare Power of Attorney, to provide consent on behalf of the person.

The registered manager told us they had identified the need for some improvements to ensure their compliance with the MCA and they showed us improved documentation they planned to implement.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate. Appropriate action had been taken to comply with conditions specified in DoLS authorisations. However, we did identify that staff knowledge of conditions was variable and improvements were required to ensure all staff were aware of their duties in this area.

People told us they were supported with their health and well-being and staff made contact with relevant healthcare professionals as needed. One person told us, "They were very quick to get a doctor when [person] had a bad chest infection." A relative said, "The district nurse comes to see [relation] every week to check on them, check their dressings and make sure they are ok."

The outcomes of appointments with professionals including GP's and specialist nurses were recorded in people's care plans. However, when people had specific health conditions, care plans did not consistently contain adequate detail in order for staff to provide effective support. For example, one person had recently experienced a seizure but there was no information about this in their care plan. Information in other care plans may have been confusing for staff . Another person's care plan stated their blood sugar levels should be checked weekly but we could not find any records of this. The deputy manager said they would not normally check blood sugar levels, unless it was an emergency. This was not clear in the care plan. In addition to this we also found staff were not always aware of the signs of people's health needs

deteriorating, such as signs of low blood sugar levels or indicators of a seizure. These inconsistencies in care planning and staff knowledge placed people at risk of not receiving the required support.

Systems were in place to ensure information was shared across services when people moved between them. The provider conducted in-depth assessments of people's needs prior to them moving in to the home, and this was then used to inform a care plan. They also had a discharge plan which they used to facilitate the process when people left the home. In addition, the registered manager told us the electronic care planning system was used to generate an emergency summary sheet of people's needs if they went into hospital. This was accompanied by the latest medicines record and information about advance decisions to ensure care was person centred.

People were supported by staff who had the skills and knowledge to provide good quality care and support. People told us they felt staff knew what they were doing. One person told us, "I would say most of them know what they are doing, although some are better than others. I would think they have had training." A relative said, "I would say they are trained they need to be qualified to do this job." Another relative commented, "I think they are trained. They come in to help our relative in pairs. I think they know what they are doing."

Records showed that overall staff had received the relevant training to equip them with the knowledge and skills they needed to support people who used the service such as safeguarding, health and safety and infection control. New staff were provided with an induction period when starting work at the service. A recently recruited member of staff told us the induction included training and shadowing of more experienced staff. New staff had completed the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support. Staff told us they felt supported and records showed they had regular, in depth supervisions to discuss any concerns and identify any training and development needs.

Bluebell Lodge is situated in a purpose built premises. Consideration had been given to people's needs in the design and decoration of the building. For example, aids and equipment had been installed in some areas to enable people with mobility needs to navigate around the building and the provider had installed a call bell system to ensure people could request staff as required. There was a communal lounge area on each floor and a separate dining area which meant people had ample space to spend time socialising with friends and family. People's needs associated with dementia had been taken into account in the design and decoration of the environment. Dementia friendly signage was used throughout the building and pictures and sensory objects were used to help people orientate themselves.

Requires Improvement

Is the service caring?

Our findings

People told us they were involved in decisions about their care and support, however this was not always the case. We saw a number of occasions where staff did not consult people about their care and support. On one occasion a member of staff shouted across the room to another member of staff, "Shall we move some of these (people living at the home) then?" They then shouted a list of names and we observed they started assisting these people to move. None of these people were consulted about this decision. On another occasion, early evening, around 15 people were in a communal area relaxing and watching TV. A member of staff asked another member of staff to turn the lights on. The lights were turned on, people appeared dazzled by the brightness, and some commented on this. No one was consulted about this. A third person told us they were not offered a choice of food, they said, "They just bring something up for me." This meant people were not always consulted about their care and support.

During our inspection, we received information of concern that people were assisted to get up too early in the morning. We informed the registered manager about this who told us they would investigate the concern and feedback to us. Following our inspection the registered manager told us they not found any concerns and said they had taken action to emphasise the importance of respecting people's choice with the staff team anyway.

People's right to privacy was not always respected. Three people told us other people living at the home frequently entered their bedrooms uninvited. This happened twice during our inspection. On one occasion a person was in bed unwell, we saw another person, who lived at the home, entered their bedroom and walked around shouting loudly. The person in bed looked startled. We intervened to find staff who then moved the person to a communal area. Another person commented they did not have any privacy when using the phone to call their relatives. We saw the phone was in the main communal lounge and found that phone calls could be easily overhead by others living at the home, staff and visitors. One person told us, "It is not quiet in here you can hear everything, it's not very private. You can hear all the phone calls." Additionally, one person had information about their mental health needs and 'non-compliance' with care displayed on the outside of their bedroom door. This did not respect the person's right to privacy or promote their dignity. People's bedroom doors had a sign displayed stating 'personal care' was in progress, these signs aimed to prevent people from entering bedrooms when they were being assisted with personal care. However displaying information about people's intimate care needs on their doors did not respect their right to privacy and in addition, the signs were not effective as staff did not use them at all throughout out visit.

Staff did not always take action to protect people's dignity. For example, we saw a person take another person's drink and drink some of it. A second person then came and picked up the same drink and drunk the remainder of it. Staff observed these two people consume the drink that did not belong to them but did not intervene to prevent this and preserve their dignity. We also noted that during the day, particularly at mealtimes, staff talked about and commented on, the people they were assisting in front of them and others. Following our inspection the registered manager advised us they planned to address this with the staff team.

An inconsistent approach had been taken to personalising the environment. For example, some people had personalised displays on their bedroom doors whereas other people did not. Most people's bedrooms were personalised and homely, however we saw some unnecessary items were stored in people's rooms. For example, one person had a commode in their room but they did not use this.

The above information was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were positive about the caring approach of staff. One person told us, "They (staff) are very kind, nothing seems any trouble, and they know me well." Another person said, "The staff are absolutely kind and caring, they have to put up with a lot here. I know it is their job but they are always good. If you have a gripe or a grumble they take it." A relative told us, "I think they are very caring. They like my relative and [relation] is always grateful for what they do, I think it makes a difference. When [relation] was feeling a bit stronger they took them out to the local bakery which I thought was really nice, they did not have to do that." Another relative commented, "I do think they are caring, they have a very difficult job." During our inspection, we found staff were kind and caring, and on the whole, responded to people with warmth and compassion. For example, one person became distressed at a meal time, a number of staff responded to calm the person and encourage them to eat their meal. Most people told us they felt staff knew them well and people's care plans contained information about their background and their preferences.

Staff had a good understanding of people's communication needs and used this to inform their support. Care plans contained information about people's communication and staff demonstrated a good knowledge of this. For example, one person communicated through facial expressions and body language. We saw staff were quick to identify what the person wanted and used a process of elimination when this was unclear. The registered manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. One person had been referred to an Independent Mental Capacity Advocate (IMCA) at the time of our inspection. IMCA's are a legal safeguard for people who lack the capacity to make specific important decisions.

People were supported to maintain relationships with friends and family and people's friends and relatives were welcome to visit Bluebell Lodge. Some relatives commented they were able to have meals with their relatives. There was a restriction upon a visitor to the home but appropriate processes had been followed to ensure people's rights had been respected. There were no other restrictions upon visitors to the home. People were supported to develop and maintain relationships with other people living at the home. We saw people had developed close friendships and they were supported to spend time with each other.

People were supported to maintain their independence. This was reflected in feedback from those living at the home. One person told us they were able to go out independently. People's care plans included information about areas where they were independent and where they needed support.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support that did not meet their needs. Each person living at the home had an individual care plan; however, the quality of these was variable. In some cases, the information was not specific. For example, when people were at risk of developing pressure ulcers their care plans contained phrases such as 'introduce repositioning schedule tailored to their needs,' rather than stating the frequency of repositioning required. The care plan for a person with a urinary catheter provided information about emptying the catheter bag regularly but did not provide information for staff as to who to contact if there were problems with the catheter. Other care plans were confusing and contradictory. For example, one person's care plan gave instructions for how to support the person to access the toilet, however later in the plan it stated they were unable to access the toilet and staff confirmed this to be the case. This placed people at risk of inconsistent support.

In addition to the above, staff were not always using care plans to inform the care and support provided. Four of the seven staff we spoke with told us they had not read any care plans. A fifth member of staff said they had looked at a few, but not all of them. One member of staff said, "I have never looked at a care plan, I would not know what to do with it." Staff told us they were provided with information about people's support needs at handover. If they were away for a few days they mentioned this at handover and were able to ask for any additional information they needed. This did not assure us staff had adequate information to inform their care and support. The failure to use care plans to inform support had a negative impact on people living at the home. One person's care plan stated they should not be left unassisted whilst eating. Despite, this we observed this person was left unsupervised and furthermore they were eating a food which was against professional recommendations specified in their care plan. This failure to follow care plans placed people at risk of unsafe and inconsistent support. The registered manager advised us they would address this with the staff team.

Staff were not always responsive to people's needs. For example, we heard one person calling out for a period of around 10 minutes, this could be heard from the main corridor and we observed a number of staff walk past without attending to them. We intervened to seek staff support and staff told us the person was uncomfortable and required repositioning. We also saw multiple occasions where a person living at the home took food and other items from others, on some occasions there were not staff present to intervene, we observed and people told us this caused them distress. On another occasion a person requested assistance to move to another area of the home. Staff were busy supporting another person and told the person to wait. They waited for a period of approximately 10 minutes and in this time became visibly agitated making comments about being left to wait.

The registered manager told us people's care plans were developed using preadmission assessments and people were offered the opportunity to be involved in regular reviews. No one we spoke with could recall being involved in the development of their care plan, however people's relatives told us they were involved.

People had been offered the opportunity to discuss their wishes for the end of their lives and this had been sensitively recorded in their care plans. People's medical needs had also been considered, for instance, one

person had medicines prescribed to relieve any pain and distress they may experience in their last few weeks of life. Where people had made an advanced decision to refuse certain type of medical intervention this was clearly recorded in the care plan and the appropriate documentation had been correctly completed.

Overall, people's diverse needs were recognised and accommodated. The registered manager told us they accommodated people's religious needs by respecting people's prayer routines and preparing food using culturally sensitive methods. However, it was unclear how other people's religious needs were met. One person's care plan documented they would like to attend church services, they were no longer physically able to do this, but the care record did not indicate that alternative arrangements had been put in place. The registered manager told us they recognised the importance of respecting other individual needs such as sexual orientation and gender identity and disability.

People were provided with some opportunity for social activity. Feedback from people who used the service was mixed. While some people told us there was enough to do, other people told us opportunities were limited. One person told us, "I just watch the TV I am happy, but there is nothing to do here." The service had a designated activities coordinator who had only been in post for a short period of time. During our inspection, we saw they were enthusiastic about their role and provided a range of group and one to one activities including feeding the birds and craft. We noted that the activities coordinator was often the only staff member available in communal areas and was consequently required to assist people with their support needs. This impacted on their ability to facilitate activities.

There was limited evidence to demonstrate how people's individual preferences and interests were used to inform the opportunities and activities on offer. We also observed that the opportunities available to people could be further improved by ensuring consideration had been given to people's diverse needs such as those associated with dementia or sensory loss. We discussed activities with the registered manager who told us they would be supporting the activity coordinator to further develop activities to ensure they met people's needs.

Opportunities for meaningful activity and involvement in the running of the home had been missed. An activities timetable showed people were offered the opportunity to get involved in a 'housekeeping' activity. However, this approach had not been incorporated in the daily routines at the home. We heard one person asking the house keeping team if they could help them with housekeeping activities. The member of staff told the person they could not get involved. This meant an opportunity to provide the person with meaningful activity by involving them person in the running of the home was missed. Other people's care plans documented they enjoyed getting involved in laying and clearing tables at mealtimes; however, on the day of our inspection people were not offered the opportunity to do this.

The management team explained how they met their duties under the Accessible Information Standard by providing information in different formats as required. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. We saw examples of pictorial menus and other communication aids which were used to enable people to access information.

There were systems and processes in place to deal with and address complaints. People told us they would feel comfortable telling the staff or registered manager if they had any complaints or concerns. One person told us, "If I had a complaint I would see [registered manager] the information is also pinned up in my room." Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. Staff told us they were confident the registered manager would act upon

complaints appropriately. There was a complaints procedure on display in communal areas and in people's bedrooms, informing people how they could make a complaint. We reviewed records of complaints, there had only been one and this had been investigated and responded to in a timely manner. The registered manager had had apologised for any distress caused and had made improvements as needed.

Requires Improvement

Is the service well-led?

Our findings

There were no formal systems in place to identify and address issues with the day to day practice of staff. For example, we found concerns about staff not following guidance in care plans, unsafe staff deployment and a failure to involve people in decisions about their care and support. We discussed this with the registered manager who acknowledged our concerns, and advised they intended to increase the amount of time they spent working with staff to better monitor their practice.

Records of care provided were not completed in a timely manner and this increased the risk of errors. The provider had implemented an electronic care planning system and staff had access to a computer and laptop which they used to update care records. Staff told us, and we observed, they did not have adequate access to IT equipment to enable them to update care records immediately after care had been provided. We saw a member of staff completing all care records a significant time after the care had been provided, they relied upon their own and other staffs' memory about what people had eaten and when they were last repositioned. This was not a safe or effective method of recording care provided and posed a risk inaccurate information may be recorded about the care delivered. We discussed this with the registered manager who had identified this as an issue. They advised us they had discussed this with the provider but had not yet reached a solution.

People's care records were not always accurate and up to date. The registered manager was aware of the issue and explained that care plans were a work in progress due to a recent transition to electronic care plans. We saw evidence that the manager had identified issues with care plans and had taken action to start to address this with the care plan coordinator.

We checked our records which showed the registered manager had notified us of most events in the home. A notification is information about important events which the provider is required to send us by law such as serious injuries and allegations of abuse. We identified the manager had not informed us of all safeguarding referrals made to the local authority. We also identified another occasion where we were not notified of a person's death in a timely manner. A failure make notifications as required impacts upon our ability to monitor the service. The registered manager explained this was due to a misunderstanding of their duties and they assured us they would notify us as required in the future.

People and their relatives were positive about the quality of the service provided at Bluebell Lodge. One person told us, "I would not change anything, I have everything I need." A relative commented, "This is a much better place (than other homes) it is smaller and more together, [relation] is being looked after and is very happy." People who used the service and their families were supported to have a say in how the service was run. Regular meetings were held for people living at the home and their relatives. We reviewed the minutes of the last two meetings and saw changes in staffing at mealtimes were discussed, and the creation of a sensory area and timetable of activities. During our inspection we saw some action was underway to address this, such as the introduction of a timetable of activities. Additionally, people and their relatives were invited to share their feedback in regular quality assurance surveys. These were conducted on an annual basis for staff, relatives, people using the service and professional visitors and were based on each of

the CQC key questions; is the service safe, effective, caring, responsive and well led.

Relatives and health professionals told us communication with the staff and management was good. A relative said, "There have been meetings I think and they also have newsletters. We visit at different times of the day. They (staff) always give us an update on [relation] when we arrive and are quick to tell us if there is anything we need to know." A health professional commented, "The staff know people well, we always get the information we need, it is very much family focused."

Staff were given an opportunity to contribute to the running of the service in regular meetings.
We reviewed minutes of recent staff meetings. These showed a range of issues were discussed including standards of care, record keeping, medicines administration and the attitude of staff. Action was taken to address the issues and suggestions raised at meetings. For example, in a recent meeting staff had raised concerns about staffing levels at night. As a result the number of staff had been increased from two to three. Staff told us they felt well supported and understood their roles and responsibilities. They were aware of their duty to whistleblow on poor practice and felt confident in raising any concerns with the registered manager.

The diverse needs of the staff team were recognised and accommodated. A member of staff explained how they had been supported by the management and staff team with some specific needs they had. They told us this had made them feel part of the team and well supported.

There was a registered manager in place who was passionate about her role and took pride in the service. People were positive about the management and leadership of the home. One person told us, "I think it is well managed we sometimes see the manager." Another person commented, "I think she does the best job she can." Staff were also positive, they said the manager was available for them when they needed her and was supportive. They said she was fair and "didn't make an issue out of anything." There was a clear management structure within the service including a deputy manager and senior carers who supervised the day to day running of the service. Some staff also had lead roles, in areas such as care plans or medicines management.

The registered manager linked with other local services and took part in local management forums to keep up to date with best practice. They also used the internet and received updates from nationally recognised organisations to ensure they stayed up to date.

There were systems and processes in place to monitor and improve the quality of the service. The management team conducted a wide range of audits across the service such as auditing the environment, medicines, care plans, health and safety and infection control. Regular audits were also carried out by the provider. Overall, we found where any issues were identified, actions were recorded as being taken. However, as mentioned above, additional measures were required to monitor the day to day practice of staff. Patterns and trends of accidents and incidents were analysed and there was evidence that improvements were made as a result.

Throughout our time at Bluebell Lodge the management team were open and receptive to feedback and took swift action to rectify areas of concern. We gave feedback to the registered manager on the issues found at our inspection. Following our inspection they provided us with an action plan detailing actions already taken or planned.

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 10 HSCA RA Regulations 2014 Dignity and respect People's right to privacy was not respected at all times and people were not always treated with dignity. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected from the risks associated with their care. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff available to meet people's needs and ensure their safety. 18 (1)