Primrose (2013) Limited

Blackdown Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Blackdown Nursing Home provides care and accommodation for up to 33 people who may require nursing care or who are living with dementia. At the time of the inspection 31 people were living at the service.

The first day of the inspection was unannounced. We informed the registered manager of the date of the second day of the inspection so they could be present.

At the last inspection in December 2016 we found three breaches of regulation and the service was rated as requiring improvement overall and in the safe, effective, responsive and well-led areas. Caring was rated as good. As a result, requirements were made to ensure the service complied with the Mental capacity Act; to ensure risks to people's health and safety were properly assessed, recorded and acted upon and aspects of medicines management were improved. A requirement was also made to ensure the quality monitoring systems in place were improved.

Following the inspection, the provider had developed an action plan to ensure improvements were made. The service has also worked in partnership with the local authority quality assurance and improvement team to improve their systems and processes. Prior to this inspection we met with the provider and registered manager to review their action plan. We found some improvements had been made at this inspection. However further improvements were still needed.

This comprehensive inspection was brought forward as prior to this inspection the registered manager had notified us of two incidents, which resulted in harm to people using the service. We wanted to ensure risks to people's health and wellbeing were appropriately managed. We also received anonymous concerns about practice which indicated people's preferences about when personal care was delivered may not be met.

A new manager was appointed at the service in May 2017 and registered with the Care quality Commission in July 2017. 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.

People received their medicines safely and when they needed them. However some medicine practices could be improved.

The registered manager had introduced a range of audits and systems to enable them and the provider to monitor the quality of the service provided. These were beginning to have an impact. However, the quality assurance system was not always effective because issues identified at the inspection had not been recognised. Improvements were needed to ensure people were protected from the risk of fire and that all parts of the premises were clean and odour free.

Improvements were required to ensure people's daily personal care was always personalised and responsive to their needs. Mealtimes were not always well organised or sociable occasions. The physical environment of the service had not been adapted to meet the particular needs of people living with dementia and maximise their independence. People living with dementia would benefit from activities based on current good practice guidance for dementia care.

People said they felt safe. Improvements had been made to ensure assessments identified people's specific needs or risks, and showed how risks could be reduced. There were systems in place to review accidents and incidents and the registered manager ensured action was taken where necessary to reduce future risks.

Staff had been trained to recognise abuse. The registered manager and staff understood their responsibilities to report any concerns. There were sufficient staff to ensure people's needs were met, when there were no unplanned staff absences. Staff had opportunities for regular training to enhance their skills and knowledge.

Improvements had been made to ensure people's rights were protected as the registered manager acted in accordance with the Mental Capacity Act 2005.

People's nutritional needs were met. People had access to a variety of health professionals for specialist advice and support when appropriate. The service had developed good working relationships with health and social professionals.

People said the staff were friendly and kind. We observed staff speaking to people in a friendly, warm and politely way. People knew how to raise concerns and the registered manager dealt with concerns in a timely way to resolve them quickly where possible.

Improvements had been made in relation to some records. Care plans contained detailed information about people's health needs and how these should be met. Records showed that staff had taken appropriate actions to alert health professionals where risks to health had been identified.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have made a recommendation relating to the management of medicines.
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 always safe.

Attention was needed to ensure people were protected from the risk of fire.

Not all parts of the premises were clean or odour free.

Improvements were being made to ensure staff recruitment was fully robust.

People were supported to have their medicines safely. Improvements were being made to improve records.

There were sufficient staff to ensure people's needs were met, when there were no unplanned staff absences.

Risks for people who used the service were identified and risk assessments were in place to ensure known risks were mitigated.

Staff had received safeguarding adults training and were confident they could recognise abuse and knew how to report it.

Is the service effective?

Good

The service was effective.

Mental Capacity Act 2005 (MCA) assessments were completed and in line with legal requirements.

People were supported to receive adequate nutrition and hydration. They had access to health care professionals for regular check-ups as needed.

Staff were appropriately trained and supervised to provide care and support to people who used the service.

Is the service caring?

Good

The service was caring.

Staff were caring in their approach and interactions with people. They assisted people with patience and offered prompting and encouragement where required.
Staff respected people's privacy and knew people's preferences well.

Relatives and friends were encouraged to visit at any time and they said they were made to feel welcome during their visits.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provision of activities available for people was not always suitable to stimulate and engage them.

The daily personal care delivered to people was not always personalised or responsive to people's needs.

Mealtimes were not always well organised or sociable occasions. The physical environment of the service had not been adapted to meet the particular needs of people living with dementia and maximise their independence.

Care plans had been written with the involvement of people where possible and/or their families.

The service had a complaints procedure and people were aware of how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality monitoring arrangements were not fully effective. This was because they had not identified the concerns and breaches of regulations we identified at this inspection. However the new registered manager was having a positive impact at the service and staff spoke highly of them and the improvements achieved so far.

Systems for obtaining the views of people who used the service were in place and people's suggestions were acted upon.

The staff worked in partnership with other health and social care professionals in managing people's mental and physical health.

Blackdown 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 checked 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.

The inspection took place on 30 August 2017 and 4 September 2017. The first day of the inspection was unannounced; the inspection team consisted of one adult social care inspector, a medicines inspector and an expert by experience. An expert by experience is a person who has experience of using, or caring for someone using, this type of service. The second day of the inspection was completed by two adult social care inspectors.

We reviewed all information the Care Quality Commission (CQC) held about the service before the inspection. This included all contacts about the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

The CQC had received information of concern from the registered manager relating to two incidents, which indicated potential concerns about the management of risk relating to swallowing/choking and falls. This inspection examined how those risks were managed.

Some people using the service were unable to provide detailed feedback about their experience of life at the home. During the inspection we used different methods to give us an insight into people's experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not comment directly on their experiences. Our observations enabled us to see how staff interacted with people and see how care was provided.

We met most of the people who lived at the service and received feedback from eight people who told us about their experiences. We also spoke with five relatives. We spoke with 15 members of staff including the registered manager; clinical nurse lead; registered nurse; activities co-ordinator; and care and ancillary staff. We received feedback from six health and social care professionals. These included two GPs; a social

services manager; a dietician; a speech and language therapist and a tissue viability nurse.

We reviewed the care records of seven people. We also looked at a range of other documents, including medication records, three staff recruitment files and staff training records, and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found improvements were required in relation to the management of medicines; risk assessments were not always up to date and did not always give clear guidance about the risks to people. For example weight loss and information from incidents was not always acted upon to help reduce the risk of reoccurrence. Aspects of fire safety also required improvement.

With the exception of fire safety, improvements had been made to ensure safer medicines management; management of incidents and accidents and the management of risks to people's health and wellbeing. However, improvements were still required in relation to fire safety. Improvements were also required in respect of the cleanliness of the service.

The registered manager explained a new fire risk assessment had been completed recently by an external professional and they were waiting for the report and recommendations. They agreed to share this with Care Quality Commission (CQC). We found improvements were needed to ensure people were protected in the event of a fire.

The sunflower lounge had two fire doors which led on to a small patio area. Both fire doors were blocked by chairs used by people. We discussed this with the registered manager and maintenance person who said people moved the chairs. However, there was no system in place to check that fire doors were kept clear. During the visit the registered manager moved the chairs in the lounge to ensure the fire exits were clear. The small patio area outside the fire doors had a small drop with only posts in the ground and no barrier to prevent falls. The registered manager explained there were plans to put fencing against the posts to make the area safe. However in the meantime this hazard had not been risk assessed and no measures had been taken to keep people safe should they need to use this means of escape in a fire.

Regular checks had not been undertaken to ensure fire safety equipment was in good working order. For example, weekly fire alarm tests were required but we found deficits in relation to May, June, July and August 2017. Emergency lighting checks had not been completed monthly, for example no checks were recorded for May or June 2017. This meant there was a risk any faults may not be identified quickly. In July four emergency lights were found to be faulty. Two had been replaced but the maintenance person explained that they were waiting for the fittings for the other two. This meant in the event of an emergency, emergency lighting may not be effective to assist people to leave the building. The maintenance person was aware of the need to complete regular fire safety checks, and commented, "No excuse for records not being completed, just busy…" During the inspection, the registered manager combined all fire safety checks into one folder, to reduce the risk of checks being missed. We have shared this information with the Devon and Somerset Fire and Rescue Service.

These findings evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager sent us confirmation that work to build a fence to enclose

the patio area and make it safe would start on 3 October 2017. In the meantime the maintenance person was working around the weather to make sure that the slabs were secured with sand. The provider also shared the outcome of the recent fire risk assessment completed by an external professional. An action plan had been developed to address areas of concern however no timescales for completion were included. The registered manager submitted a second action plan which showed where actions had been completed and provided completion dates for other improvements.

Other aspects of fire safety were satisfactory. For example an external company visited to service and maintain firefighting equipment. Doors throughout the building had keypads which were linked to the fire system and would go to default when the alarm functioned so the doors could be opened easily. Personal emergency evacuation plans (PEEPs) were in place, which detailed how people would be alerted to danger in an emergency, and how they would be supported to reach safety. Staff had received fire safety training to ensure they knew their roles and responsibilities when protecting people in their care.

Parts of the premises were not clean or free from odours which were offensive and unpleasant. On both days of the inspection there was a strong smell of urine in the 'Sunflower lounge' were people spent their time and ate their meals and snacks. The smell of urine was apparent early in the day and this became progressively worse as the day went on. Some of the smell originated from the furniture and the fabrics. One upholstered chair in the Sunflower lounge was soiled; staff said they had 'cleaned it' but this chair was wet and had not been removed. It was left in the lounge were people were sitting and had their meals and the smell was unpleasant.

A bedroom on the ground floor close to the Sunflower lounge also had a strong smell of urine. Staff said one person entered bedrooms belonging to other people and used them as a toilet. A bedroom on the first floor also had a strong unpleasant smell of urine.

A relative responding to a satisfaction survey in July/August 2017 had raised concerns about the unpleasant smell, writing, "Smell of urine is quite unpleasant at times." As a result of that comment, the provider arranged for an external contractor to undertake a 'deep clean' of the carpets and fabric in the communal areas in July 2017. The provider also spoke with housekeeping about the deep cleaning of people's bedrooms.

The floor of the toilet located outside the Sunflower lounge was stained. The bottom of the toilet basin and the lid to the cistern was wood, which did not promote effective cleaning or infection control. The manager had completed an infection control audit in May 2017; however the audit did not identify this. The registered manager confirmed the provider was aware that repairs were required to the toilet.

Some of the soft furnishings were dirty (with food debris) and worn, for example people's arm chairs in communal areas.

The environment did not always meet the needs of people living with dementia. Some people were walking up and down the corridors but there were no particular areas of interest or sensory items to keep them occupied or engaged. There was no pictorial signage on the doors to help guide people to find communal areas or bathroom and toilets. Over the course of the inspection there were 12 or 13 people in The Sunflower lounge, however there were only 12 soft arm chairs. One person sat in their wheelchair during the morning and until after lunch. The room was crowded, and some people's chairs were very close together, which led to some minor altercations when people invaded other's space. We observed people rarely moved from their chairs. The registered manager said they felt there were "too many people in the Sunflower lounge…" They said they would be speaking with the provider to use the 'quiet lounge' by the main front door, which

was rarely used. The registered manager told us that they had intentions to improve the environment for people living with dementia but that they were concentrating on ensuring the service was fully compliant with previous breaches of regulation.

We observed there was insufficient tables and seating to offer people the choice of where to eat their meals. At lunch time seven people sat at the tables in Sunflower lounge and six people sat in soft chairs with lap tables eating their meals. No one was offered a choice of where to eat their meal. We spoke with staff about the seating arrangements. They told us this is where people usually sat when in the communal areas.

These findings evidence a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in December 2016, medicine management was not safe, as people's medicines were not always stored or disposed of safely and there was no audit in place to help ensure medicines administration followed best practice. The provider's action plan detailed the improvements they planned to make to medicines and we found progress had been made and was ongoing. We have made a recommendation for good practice.

People's medicines were managed safely. There was a system in place for ordering, receipt and disposal of medicines. Records were completed of medicines that had been received into the service. Medicines that were in use were stored safely; medicines awaiting disposal were stored separately with records made. There were suitable arrangements for the storage and recording of medicines requiring extra security. Regular checks had been made for these medicines and they had not identified any issues. Where refrigeration was required, medicines were kept in a dedicated medicines fridge and the minimum and maximum temperatures were recorded daily to ensure they were stored at the correct temperature.

There were no gaps in the medicines administration records (MAR) and medicines were given to people as prescribed, except for one medicine which was not administered at the times that it was prescribed. This meant that some doses were too far apart and some too close together and therefore the person may not derive the maximum benefit from this medicine. By the second day of the inspection the clinical lead nurse had obtained a new MAR which clearly set out the times the medicine was required to be given. The MAR for one person was handwritten and did not have the allergy status recorded. This handwritten MAR had not been signed by staff members to show it had been checked for accuracy.

The application of creams and other external items were recorded on an electronic system. We checked four of these electronic records. There were instructions to guide staff about when and where to apply the preparations; however, the records were not completed at the time for which the medicines had been prescribed. The registered manager recognised the records did not demonstrate that external medicines were being applied as prescribed and was in the process of printing out the electronic information to remind staff of when and where to apply these medicines.

For medicines prescribed 'when required' there was not sufficient information with the MAR charts about how or when these medicines were to be given. We also found care plans relating to medicines were not in place and therefore there was no guidance for staff on when to administer 'when required' medicines they were prescribed, for example for pain relief. Although there was no written information to guide staff about when to give a medicine prescribed when required, staff knew people well and medicines were given when needed. The registered manager was aware this was an area that needed further work and was in the process of addressing this issue.

We recommend the National Institute for Health and Care Excellence (NICE) guidelines for managing medicines in care homes March 2014 be followed.

That the electronic records for administration of creams and other external items are made in accordance with information on the printed MAR charts. We also recommend care plans are in place for complex medicines and information for the administration of 'when required' medicines is kept with the MAR charts.

The opening dates of creams, eye-drops and liquids were recorded to ensure that these were discarded within the required time range, to reduce the risks of infection and ensure that they were effective.

Staff were appropriately trained, knowledgeable with regards to people's individual needs related to medicines and confirmed they understood the importance of safe administration and management of medicines.

Recruitment checks on prospective staff were completed. However; they did not include information about their full employment history, nor were gaps in employment history explained within the recruitment records. Discussing gaps in employment history would ensure people were protected from staff who may not be fit to work with vulnerable people. By the second day of the inspection the registered manager and administrator had reviewed the application form, to ensure there was sufficient space to record employment histories. Other checks were present and had been obtained prior to new staff starting work at the service. For example, application forms, proof of identity, two references from recent employers and a satisfactory Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have.

People who were able said they felt safe at the service. One person said, "There's nothing too much wrong here. I am comfortable…" Another person said, "It's nice here. I am happy…If I am not sure about something I ask and they tell me what I need to know." The majority of relatives also felt the service was safe. However one was concerned about the level of staff presence and supervision in communal areas at times and felt that people may be at risk of falls without a constant staff presence. During the inspection there was always a member of staff in the Sunflower lounge and staff were generally present in the Lavender lounge. One person was concerned about their belongings and wished to lock their room door when they were not in their room. We spoke with the registered manager about this and they explained that people could have keys to their room if they wished. They said they would arrange for the person to have a key to secure their room when they were out.

People's nutritional risks had been assessed and they were weighed regularly to monitor any weight loss. Where concerns had been identified action had been taken. For example, referrals had been made to the GPs for advice and the registered manager had introduced daily fortified milk shakes and smoothies. Two GPs said any concerns were reported to them in a timely way. Two people had been referred to dietician due to concerns about their dietary intake. A dietician explained, "The risk had been identified and acted on. They (staff) were doing what they could, fortifying diets and providing additional snacks. We have advised additional supplements and they have taken that advice. The registered nurses have been very helpful… they are knowledgeable about their patients…"

Other potential risks were identified and guidance was in place to reduce potential risks related to the risk of falls, skin damage, challenging behaviour, moving and handling and risks of choking related to swallowing difficulties.

Two people had been identified as being at risk of choking and referrals had been made to the speech and

language therapist (SALT). The guidance given by the SALT was available in people's records and was highlighted on the dietary sheet, which staff had access to, including the kitchen staff. A competency sheet was in place for staff to sign to confirm they had the knowledge and the skills and were therefore accountable when supporting people at mealtimes. We saw people were given the correct texture of food and assisted to maintain the correct posture during mealtimes to reduce the risk of choking or food aspiration. A SALT told us senior care staff were "very good" and understood the recommendations they had made to keep people safe whilst eating.

People at risk of developing pressure damage to their skin had the appropriate pressure relieving equipment in place. Monitoring analysis included pressure mattress settings and these were checked regularly by a team leader. Pressure relieving mattress settings were aligned to people's weight to ensure they were effective. A tissue viability nurse specialist said staff did need guidance about which dressings to use but always follow their professional advice. They confirmed the service had been prompt in making referrals and the appropriate equipment was in place to reduce the risk of skin damage.

Improvements had been made to the reporting procedures and the analysis of accidents and incidents. As a result of the analysis of accidents, falls in particular, the registered manager had recognised a higher risk of falls between 5pm and 10pm. They found this was a busy time; people became more restless and it was difficult to ensure a staff presence in the communal areas at these times. In consultation with the provider the need for an additional staff member had been agreed to cover this time period. The registered manager explained they planned to introduce the additional member of staff within a week or so of the inspection and recruitment for the post was underway.

There were sufficient staff to meet people's care needs when there were no unplanned staff absence. The provider used a tool to assess the dependency of people according to their care needs, which informed them of the numbers of staff hours needed to meet those needs. This was used regularly to determine staffing levels. On the first day of the inspection one member of staff had called in sick. One staff member said, "You can't help sickness…" A nurse said sickness levels amongst staff were low.

Staff were focussed on meeting people's needs. However on the first day of the inspection there were 12 people in the Sunflower lounge, many living with dementia and only one staff member present at all times. Other care staff came and went for short periods of time, for example bringing refreshments or assisting at lunchtime, but it was mainly one member of staff looking after 12 people for the majority of time. This meant people didn't always get the individual attention or help they needed. For example, one person was incontinent and the staff member had to wait for 10 minutes for other staff in order to assist. Another person's behaviour impacted on other people. For example, they shouted or reached out to others; at one point pulling at someone's newspaper. The staff member was unable to monitor; supervise; intervene and support people at all times. There were no staff absences on the second day of the inspection. We noted additional staff presence in communal areas, and staff had time to be more attentive and responsive, meaning people's needs were met in a timely way.

Staff said there were usually enough staff to meet people's needs but due to sickness they were short on the first day of the inspection. They described how 'good team work' helped to ensure people's needs were met. For example, the registered nurses and activity co-ordinator assisted people at mealtimes.

The registered manager explained that staff recruitment was on-going but they had experienced difficulties due to the location being rural. They experienced particular difficulties recruiting registered nurses. Some agency staff were used. A regular agency nurse provided cover for some night shifts and an agency carer provided support with one to one care for one person. The registered managed used the same agency staff

when possible to promote continuity of care. The registered manager said "…if you want good quality staff you need to be selective."

Sufficient numbers of ancillary staff were also employed, such as housekeeping and kitchen staff, and maintenance staff to undertake cleaning, laundry and the preparation of meals.

The registered manager and staff were aware of the types of abuse and their responsibility to protect people from abuse and harm. They had received training about safeguarding of adults and were aware of how to report any concerns. Staff were confident that any concerns raised would be investigated. The registered manager had notified the local authority and the CQC of any potential safeguarding issues.

Potential environmental health and safety hazard had been addressed. The temperature of the hot water supply was controlled and was within the 44 degrees limit recommended by the health and safety executive (HSE). We checked that windows on the first floor, which had been restricted to reduce the risk of people falling. There were systems in place to ensure equipment at the service was safe and in good working order For example, hoists were serviced regularly, as was the passenger lift. Electrical checks were carried out at the required intervals.

The last environmental health visit had awarded the service a top rating of five, which confirmed good standards had been maintained in respect of food hygiene.

Good

Is the service effective?

Our findings

At the last inspection we found some people's legal rights were not upheld in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This was because mental capacity assessments had not been completed for each decision people were considered not to have the capacity to make.

We found improvements had been made at this inspection.

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 made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments had been completed in order to identify whether people lacked the capacity to make decisions in a particular area. For example, about nursing or medical interventions; or the use of certain equipment, which may impact on people's movements. Where a person lacked capacity, best interest meetings were held with the person's relatives (where appropriate) and relevant professionals. The registered manager was working to ensure care plans were personalised and information about people's preferences was recorded so that staff could assist those without capacity to make day to day choices and decisions. For example decisions about their meals or how they spent their time.

The majority of people using the service were not free to leave and were under constant supervision. The registered manager had submitted the necessary Deprivation of Liberty Safeguards applications to the local authority and were awaiting a decision.

The registered manager understood their responsibilities under the MCA. Staff understood the principles of the MCA and explained they always tried to offer people choices and involved them in decisions regardless of their mental capacity. For example, a member of staff described discussing meal choices with people and showing them different foods to help their decision. Staff also spoke about gaining consent before assisting people with person care. People who were able confirmed staff sought their consent before any assistance. We observed staff assisting people to move using hoists. Staff fully informed people of what was happening, constantly checking that people were comfortable and safe.

Staff were supported with appropriate training and supervision needed to carry out their roles. They were positive about the training and support they received. Comments included, "We are getting training and the manager will get on us courses if we want…" and "The training is good. I feel happy and supported…"

Staff received a range of training and records showed staff had completed core training. For example, moving and handling; infection control; first aid; health and safety; and fire safety. Additional training was

provided to assist staff with their understanding of people's needs and conditions. For example training related to dementia care; challenging behaviour, end of life care and falls prevention. Registered nurses had received additional training in relation to diabetes and the management of PEG tubes (commonly used to provide a means of feeding when oral intake is not adequate). There was an annual training plan in place to support staffs' continued learning.

New staff were supported with induction training, to help ensure they were familiar with people's needs and worked safely. They also 'shadowed' experienced staff to help them become familiar with people's needs and help them to work safely with people. Staff received supervision regularly. This provided an opportunity for staff to discuss their work or training needs and to get feedback about their performance. One member of staff said supervision was more regular since the appointment of the registered manager. Another said they felt their competency had increased with the support of regular supervision.

People were supported to maintain their health and they had access to a variety of health care professionals. For example, GPs; specialist nurses; speech and language therapist; dietician, chiropodist and optician. Visiting health professionals said the service was proactive and referrals to them were timely and appropriate. They said good professional relationships had been established and followed their advice. One said, "Communication is very good…they make sensible decisions and I am confident that the nurses make good clinical decisions…they have an eye on the ball (when it comes to changing needs)…" Another professional told us, "The care people receive here is good…they manage difficult symptoms (relating to dementia) really well. We rely on them (staff) and have confidence in them…"

One person's mobility had been assessed and a physiotherapist had been requested by the service and their advice had been followed. A specialist sling was in use which supported the person; which kept them safe and ensured their comfort.

People were receiving foot care from a visiting chiropodist on the first day of the inspection. However some people were reluctant at first asking. Some people had to be persuaded and encouraged that it was of benefit to have their feet cared for and that they would feel much better after it had been done. One person in particular did not want their feet looked at. With support and encouragement from staff the person agreed and they seemed quite happy when they returned.

People were supported to receive adequate nutrition and hydration; their dietary needs and preferences were documented and known to the kitchen, care and nursing staff. People and their family members said the food was good and plentiful. Comments from people included, "The food is pretty good…" and "The food is nice. I couldn't do better myself…" Results from a satisfaction survey completed in august 2017 showed the majority of people rated their experience of the food as "very satisfied" or "fairly satisfied". Where people had made comments about improvements, the provider had responded. For example, ensuring that people's preference were recorded and met in relation to meals.

People were offered a cooked breakfast daily and we saw several people enjoyed this. One person said, "I like an egg and bacon. It is good…" Generally there was a choice of two meals at lunchtime, but if people did not like the main dishes of the day they could have something else, generally an omelette. Some people required pureed food due to swallowing difficulties and where possible were given the food being served that day, in a pureed form. Teas and coffees were offered at various times of the day.

One person required their nutrition to be delivered via a special tube (PEG) as they were unable to maintain adequate nutrition with oral intake. The community dietician had been involved in the person's care and a regime had been established to ensure they had sufficient nutrition and fluids. Records showed the person

was receiving the necessary hydration and nutrition as advised by the dietician. A community dietician said they had no concerns about people's nutrition or hydration. They said staff had raised concerns about a "dip" in the person's oral intake, so the risk had been quickly identified. They added, "They (staff) have been fantastic. As far as I am aware things are going well with the regime." They added that the service was proactive and kept in contact with them if there were any concerns.

Good

Is the service caring?

Our findings

Staff were kind, caring and friendly in their approach. People using the service and their relatives felt staff were caring. Comments from people included, "The staff are fine. They are helpful and chat with me"; "The staff are a friendly lot. They are very good to me…" and "Most (staff) are very nice. Others don't seem to have much time. That is the way of the world…" One person felt some staff could be "stroppy", although no examples were shared with us.

A professional commented, "Staff are calm, thoughtful, balanced and sensible…they have a good approach." Another said, "The staff are definitely caring…and very responsive to family concerns." Feedback received directly by the service, described the staff and the service people received as caring. Written comments included, "Staff go to a lot of trouble to look after (person) needs"; "A pleasant cheerful atmosphere…" and "All staff are wonderful. So kind, caring and attentive…"

Prior to the inspection we received concerns that people's preferences relating to the timing of their personal care may not be respected. The registered manager explained that people's preference for getting up; going to bed or receiving personal care were adhered to. They said some people were naturally 'early risers' because of their younger life experiences. For example one person had been a farmer and therefore had also been an early riser and this was respected. Three people confirmed their preferred routines were respected. One person said they get up and washed and dressed "when staff have the time…" People's preferred routine was recorded to guide staff.

Some peoples' family members were key in the decision for their loved ones to live at Blackdown and none felt there was any risk to the safety and care of their relatives. They were able to visit when it suited them. Some travelled quite a distance to visit their loved one. They were so happy with the care they were receiving they said they would not move their loved, even if a vacancy came up much nearer to where they lived. Comments from relatives and visitors included, "I am very happy with the care here" and "Good atmosphere. The attitude of carers is very good. (Person) is treated respectfully by the staff. I ring twice a day and am informed about anything that has changed."

The care staff on duty knew people well. Many of the people using the service were local to the area, as were some members of staff. As a result they had known each other prior to entering the service. Staff could describe people's preferences; past lives and the people who were important to them. We observed one member of staff took time to talk with relatives to learn about the history of the person and the kind of things they liked in their younger days. This then gave staff a better knowledge of the individual and a better idea of what to talk about if that person was having a 'bad day'. The relationships we observed between staff and people living at the service were good, the rapport and trust was clear.

Some people's behaviour was a challenge for staff but care staff knew people well and how to deal with behaviour which might challenge them. For example, one person's behaviour could be disruptive to others, but staff were kind and gentle when redirecting the person's attention to more positive behaviours. Some people liked to wander around the communal areas and corridors and staff supported this to lower

restlessness and agitation. We observed some staff walking arm in arm with people when restless.

Staff were aware of how to promote people's privacy. Personal care was provided in private and when staff assisted people with their continence needs, they were discreet, ensuring people's privacy. People were able to see health professionals in the privacy of their own room.

Where possible, people's independence was supported and encouraged. For example, one person liked to shop for their own food, which they passed to the kitchen staff to be cooked. This person wanted to keep a certain amount of independence and enjoyed shopping to buy the sort of foods they liked to eat. This person also enjoyed daily trips to the local amenities.

Staff adopted a positive approach in the way they involved people and respected their independence. For example, encouraging people to do as much as possible in relation to their personal care. One staff member said, "(Person's name) likes to do some things for themselves, so I always let her. It would be quicker for me to do them but it is important they have the opportunity to do things themselves…"

Staff showed empathy for people. Several told us how much they enjoyed their work and that it was important to them that people were happy and comfortable. One said, "I love my job and I feel it is important to do the best we can for people." Another member of staff said they treated people as they would like their family members to be treated; with "kindness and love…"

People's end of life wishes were discussed with them and, where possible, and documented as part of their care plan. Treatment Escalation Plans (TEP) were in place, which recorded important decisions about how individuals wanted to be treated if their health deteriorated. This meant people's preferences were known in advance so they were not subjected to unwanted interventions or admission to hospital at the end of their life, unless this was their choice. Visiting GPs expressed their confidence in staff's skill and knowledge in relation to end of care. They said 'just in case' medicines, used for people at the end of their life, were used appropriately. We saw several 'thank you' cards to expressing relatives' and friends' appreciation of the service and the end of life care provided. A GP explained a relative of a person who had received end of life recently had, unprompted, told them the care had been "excellent."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found improvement was needed to ensure peoples' care plans contained detailed information about their background and interests. Although we found some improvement, records did not consistently contain information about peoples' previous life and interests. The registered manager explained the new electronic records enabled relatives to access part of the care plans to add this personal information, but not many had done so. The registered manager explained they would remind and encourage relatives to help with this work, especially for people who were living with dementia and who would not be able to provide this information themselves.

People had limited opportunities to take part in activities suitable to stimulate and engage them, especially people living with dementia. The service employed an activities co-ordinator who worked three days a week for three hours a day. Some activities were undertaken by outside professionals. For example regular exercise and movement sessions and music and entertainment events. The activities co-ordinator explained there were less group activities as people were less interested or able. Instead they provided more one to one activities, such as massage; manicures; reminiscence and chats. We looked at the activities records of five people. Records showed people had up to two one to one sessions per months, which consisted of "chatting with staff"; "reminiscence white board" or "family visited". No other activities were recorded. There were lovely gardens surrounding the building but very few people spent any time there. The activities co-ordinator said people would benefit from more one to one time and stimulation.

On the first day of the inspection the activities co-ordinator worked in the Lavender lounge. They spent some one-to-one time people but were also engaged in assisting people with meals and refreshments, leaving them little time to engage people with activities. We observed people in both lounges during the morning. People less able to converse with others were unoccupied and either withdrawn, dozing or watching others. In the afternoon an external professional facilitated some exercise activities. The person was skilled at ensuring people were included in the activity. There was a significant difference in people's well-being during the activity. One person had enjoyed playing tennis previously and they took great pleasure in a game of soft ball seated 'tennis'. Another person who had been withdrawn or sleeping during the morning was alert, bright and smiled when their turn came to play. Another who had been either restless or sleeping expressed their keenness to join in and again showed signs of enjoyment by smiling and gesticulating. There was laughter and conversation for about an hour until the session finished.

On the second day of the inspection there were no planned activities. Again we observed people had little stimulation or occupation. Staff said they would like to see activities improve. One told us about the empathy dolls used at a previous employment. They said, "They (the dolls) were really useful". They added, "It would be nice to get people out...people with dementia need more stimulation…"

People's person care and oral care was not always well attended to. Some people looked dishevelled. For example, some people had food and other debris down the front of their clothing. Some men were unshaven, and some people had dirty hands and finger nails. One person in particular had a very dirty mouth and relied on staff to deliver all of their personal care. One member of staff was unsure how to care

for the person's mouth. We were concerned that the person may have an infection. The registered manager and clinical lead said the person's mouth did not look infected. However on the second day of the inspection a GP had visited and diagnosed a mouth infection and prescribed treatment. The registered manager said the person's teeth were brushed daily and they had a mouth care pack in their room, but no mouth care pack was in the room. A speech and language therapist said their only concern was about the standard of mouth care, which they described as "a massive issue" and "…mouths were very dirty…"

The registered manager told us personal care tick boxes within the electronic care records needed to be completed by staff to identify what care people had received. We identified several gaps in the records, in particular in relation to mouth care, which meant staff were not always completing these records or delivering the care. The registered manager said they would expect staff to always complete records to show when care was given. We could not identify if people had regular baths or showers; whether their incontinence needs had been attended to, or whether people had help with their oral care particularly for those people unable to communicate whether this had been done. We appreciated that some people living with dementia may be resistant to offers of personal care at times. However, there were no strategies in place to guide staff if this should happened. There were no checks in place to monitor whether people had received a good standard of personal care.

These findings evidence a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The mealtime experience for people needed to be improved. Mealtimes were not a sociable occasion, but rather task orientated. On the first day of the inspection one care assistant and one nurse were available in the Sunflower lounge over the lunchtime. Three people required full assistance with their meal to ensure an adequate diet was taken. Due to the time taken to assist one person we were concerned that another person's food was no longer hot. We recognised this may have been caused by the unplanned sickness absence on the day. In the Lavender lounge, staff supported people to eat at their own pace and enjoy the meal. Staff sat with people and chatted to them and encouraged them to eat.

Prior to people's admission to the service, the registered manager met with them to discuss and assess their needs and discuss the service. This helped to ensure people's needs could be met and that they and /or their family understood the service they could expect. Staff had contacted GPs and obtained copies of people's health needs which enabled them to have a good understanding of people's health history and status.

A new electronic records system had been introduced since the last inspection. Need assessments and care plans were comprehensive in most respects, and regularly reviewed. The registered manager explained the electronic records were the 'basic package' and could be built upon. For example, the electronic records contained no risk assessment in relation to swallowing or choking. However, this information was in nutritional care plans; on the dietary sheet and recommendations from professionals were kept in hard copy form.

Care records contained information about people's health and personal care needs. One person had developed a pressure ulcer and there was a detailed care plan in place identifying the areas at risk, size and presentation, the dressing in use, the frequency of the dressings needing to be changes and the cleansing solution. The nurses recorded on the system that they reviewed the areas each day. Another person lived with diabetes. Their care plan gave clear guidance about the person's normal range of blood sugars and what staff should do if they had a low reading before supper to avoid experiencing a low blood sugar over night. Care plans also considered people's mental capacity; and their preferences about how they wished to

receive their care. Records showed people and/or their relatives had been involved in the development of care plans. Handover between staff at the start of each shift ensured that important information was shared and acted upon where necessary

The provider had a complaints process in place. Four complaints had been received in the past 12 months. The registered manager had acknowledged the complaints; for three of the complaints they had investigated the issues and responded to the individual in a timely way. They registered manager said these complaints had been resolved. One recent concern was being dealt with.

The service had received several complimentary messages and thank you cards.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the provider had not ensured, by assessing and monitoring the quality and safety of the service, that contemporaneous records were in place for people or that risks to people were mitigated. No audits had been carried out of incidents and accidents to identify if any improvements could be made from any emerging themes or trends. At this inspection we found some improvements had been made but improvements were still required.

A new registered manager had been appointed since the last inspection. Staff expressed their confidence in them and described some of the improvements made by the registered manager. This included better information in care records, better communication and more regular staff supervision. One said, "She listens and gets things sorted…" Professionals also expressed confidence in the management of the service. One said, "Yes, I think the service is well-led." Another said, "Yes I have confidence in the management. The service is doing a good job…" Feedback written by one relative included, "(The registered manager) appears to have made a good start…"

Since the appointment of the registered manager a range of audits had been introduced to help monitor the quality and safety of the service. For example monthly medicines audits. These helped to ensure all medicines had been given as recorded by staff and to identify areas for improvement. Where discrepancies were noted these were investigated. A monthly 'manager's check list had been implemented and included reviews of care records; people's weights; staff ratio; call bell response time and issues relating to health and safety. The provider had also completed a 'provider's monthly checklist' for August 2017. However, our findings at this inspection showed the quality assurance system was not always effective because issues identified at the time of our inspection had not been recognised during the auditing and monitoring process. For example the shortfalls relating to cleanliness; fire safety; the environment and people's person care needs.

The registered manager had only been in post since May 2017 and recognised there was more work to be done to achieve the required standard in some areas. They had completed a self-assessment, based on the key lines of enquiry used by the Care Quality Commission (CQC) for the purposes of inspection. The registered manager had rated safe and effective as 'requires improvement' and where they had identified improvements an action plan had been developed with timescales for improvements to be achieved. Some of the timescales had not been met but the registered manager explained the self-assessment would be reviewed and up-dated.

These findings evidence a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection no effective audits were carried out of accidents or incidents to identify if any improvements could be made from any emerging themes or trends. At this inspection a comprehensive overview of all accidents and incidents had been established. Accidents and incidents had been recorded and analysed to provide an oversight of the any triggers, patterns, or times. Interventions had been

identified to try and reduce the risk of re-occurrence. For example the introduction of an additional member of staff in the late afternoon/evening time.

The provider had undertaken a recent satisfaction survey in July/August 2017 in respect of the quality of service offered. Residents and/or their relatives had been asked to complete survey forms. The questions covered most aspects of life and care at the service. The results had not been collated but we reviewed all returned surveys, which showed people were either 'very satisfied' or 'fairly satisfied' with most aspects of the service. Where the rating was lower the provider had taken some actions immediately. For example, deep cleaning the communal areas to reduce the odour. An action plan had not yet been developed to respond fully to the survey results but this work was to be undertaken by the provider.

The registered manager had introduced regular meetings for 'resident and relatives' and for all staff. Records of the residents meetings show a good attendance and a variety of issues were discussed including menus. Comments were generally positive but where people made suggestions or requests the registered manager tried to accommodate people's wishes and preferences. For example, agreeing to introduce new items such as spaghetti bolognaise. People were also kept up to date with any changes at the service, for example changes to staff and the introduction of the new electrical records, which relatives could access.

Regular staff meetings were held at the service, which gave staff an opportunity to share their opinions and feedback on the service. Minutes showed a variety of issues were discussed and staff given feedback about their expected approach. Staff felt communication had improved since the appointment of the registered manager. The registered manager said some "very honest" meetings had been held to discuss "…what needs to be done at the home…"

There was a management structure at the service which provided clear lines of responsibility and accountability. The registered manager was supported by a clinical lead nurse, whose responsibility was to monitor people's health needs and to oversee the work and supervision of other nursing staff.

The registered manager was aware of the requirement to inform the CQC of events or incidents which had occurred at the service. The commission had received appropriate notifications, which helped us to monitor the service.

The most recent CQC rating was prominently displayed in the hallway area of the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider must ensure care and treatment is appropriate and that people's needs and preferences are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider must ensure that the premises are safe for use, ensuring fire safety precautions are in place and followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider must ensure the premises are clean and suitable for the purpose for which they are being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider must ensure they operate an effective system to assess, monitor and improve the quality and safety of the service provided.