Regal Care Trading Ltd

Blenheim Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Blenheim Care Home is registered to provide accommodation with personal care for up to 57 older people in one adapted building, including care and support for those living with dementia. There were 37 people living at the service at the time of the inspection.

People's experience of using this service and what we found
The lack of oversight and scrutiny by the registered persons has failed to identify poor care practice and significant shortfalls in the management of the service, which has placed people using the service at risk of harm. There was a lack of leadership on the floor to guide staff and ensure risks and regulatory requirements were understood and managed.

Quality monitoring systems were not being used effectively to identify, capture and mitigate risks to the health, safety and welfare of people using the service. These failed to identify significant concerns relating to the standard of care, unsafe use of equipment, cleanliness and infection control, fire safety, poor state of the premises including loose and damaged wires, poor bedding and the impact of too few staff, specifically around provision of personal care and mealtimes.

Safety concerns and risks to people, such as unidentified bruising and choking were not consistently identified or addressed quickly enough to keep people safe. People were at risk of harm because staff did follow current national guidance and standards in relation to moving and handling and infection control. Safeguarding policies and procedures were not fully imbedded into practice. Staff were not clear of safeguarding process, when and how to raise concerns, which meant there were times when people's safety had not been protected.

Risk management was poor. Systems in place for assessing and managing risk had failed to identify two people occupying beds, with incompatible bedrails and mattresses which placed them at risk of entrapment. Assessments in people's care records contained limited information to guide staff on what they needed to do to mitigate risks associated with pressure wounds and choking. People's individual fire evacuation assessments had not considered all factors that may affect a safe evacuation in the event of an emergency.

The facilities and premises were not designed to enhance the wellbeing of people living with dementia. The environment needed maintenance throughout to ensure they were in good repair and safe. Infection control, including the practice for disinfecting equipment, such as commodes was poorly managed, which placed people at risk of acquiring infections. Cleaning schedules were not specific to ensure the premises was deep cleaned on regular basis to prevent the spread of infection.

Although the provider had a training programme in place, this did not ensure all staff had the skills and knowledge to carry out their roles effectively and keep people safe. Staff had a limited or no understanding

of how dementia affected people in their day to day living. There were no systems in place to test staff understanding of training delivered and minimal testing of their competence to ensure they delivered safe and effective care.

The service had insufficient staff employed to ensure staff had time to provide the support people needed, including mealtimes and make them feel that they mattered. Although staff were observed to treat people kindly, care was delivered intuitively and not driven by best practice. The culture in the service was poor, the registered manager and staff failed to recognise the impact on people being got up early in the morning and left seated in lounges all day, with little or no interaction or stimulation. Agency staff had been recruited by an agency on behalf of the provider and living on site. The registered manager lacked understanding of their legal responsibilities for checking agency staff were trained, skilled and competent before working with people in the service.

The requirements of the Accessible Information Standards were not being met. There was minimal information available to support the communication needs of people with a disability or sensory loss. 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 and in their best interests; the policies and systems in the service did not support this practice.

We have made a recommendation about consent to care and treatment being sought in line with the Mental Capacity Act 2005.

People had good access to health services which ensured their healthcare needs were being met. However, care plans needed to improve to ensure they accurately reflected people's needs and provided guidance to staff on how to meet those needs. Further work was needed to ensure people's care plans contained information about their preferences at the end of their life. People's medicines were generally managed well, however further work was needed to ensure protocols were in place to guide staff when to administer medicines on an as required basis, particularly medicines to relieve anxiety, pain and constipation.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 03 November 2017).

Why we inspected
This was a planned inspection based on the previous rating.

The inspection was prompted in part due to concerns received about poor care, unsuitable moving and handling equipment, poor training, poor culture in the service and lack of understanding about dementia care. A decision was made to bring our scheduled inspection forward for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

Enforcement
We have identified breaches in relation a lack of leadership, management and governance at this inspection. Failure to have good governance arrangements has failed to identify poor care, people not being treated with dignity and respect, poor risk management, inadequate systems for checking the premises and

equipment were safe, insufficient staff to provide care to people when they needed it, and infection control poorly managed to prevent the spread of infection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Blenheim Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector 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.

Service and service type
Blenheim Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection

We spoke with ten people who used the service and six relatives about their experience of the care provided. We spoke with the registered manager, human resources representative and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with seven staff including a senior, three care staff, the maintenance person, the cook and a housekeeper.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eleven people's care records and multiple medication records. We looked at three staff and two agency files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We wrote to the provider about the significant shortfalls identified at the inspection. Issues of concern related to poor care, unsuitable equipment, the environment, fire risks, infection control, staffing, and the failure to identify and report unidentified bruising. We asked the provider to submit an urgent action plan setting out how they had addressed each of the concerns we identified. We reviewed their action plan which provided reassurance they had taken urgent action to improve people's care, and ensure the premises and equipment were safe.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• Systems and processes for safeguarding people using the service were not established or being used effectively by management or staff.
• Staff told us they were aware of their responsibilities to raise concerns about safety incidents, but failed to do so, and lacked understanding of when this should be done.
• Staff had not consistently reported unidentified bruising and skin tears. For example, we saw one person had a significant bruise to the side of their face. Because staff failed to report this there had been no investigation into how the bruising had occurred, and no safeguarding referral had been made. The registered manager responded immediately to report this incident to the local authority safeguarding team when we brought these concerns to their attention.

Systems and processes in place to safeguard people from the risk of abuse and improper treatment were not effective. This is breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection confirming all staff were to have a supervision about the safeguarding process to ensure information about such incidents is recorded correctly and in the appropriate documents.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Systems for checking the safety of people, premises and equipment were ineffective. This meant risks to people were not identified and acted upon, exposing them to a significant risk of harm.
• People's care plans lacked up to date, relevant and personalised assessments to guide staff on how to effectively manage risk, such as pressure wounds and choking.
• We found significant shortfalls in relation to the suitability of equipment. For example, we found two people's beds had the wrong size fitted mattresses and incompatible bed rails, which exposed these people to the risk of entrapment, and or suffocation.
• Fire safety was poorly assessed and managed. We found damaged electric plugs and wiring, and airing cupboards full of bedding next to hot pipes that posed a significant fire risk.
• People's personal emergency evacuation plans (PEEPs) had not taken into consideration their individual needs. For example, if they had sensory loss, night sedation or dementia, things that would hinder their ability to leave the building safely.
• Staff had not received regular fire safety training. Fire drills had not included practising with evacuation

equipment to ensure staff were clear what to do should such an emergency occur.
• Moving and handling practices were not managed safely which exposed people to the risk of injury. For example, we saw staff pulling a person into position in to their wheelchair using the sling. This posed a risk to their skin integrity and was an unsafe use of the hoist, posing a risk to the person and/or staff. Staff were observed on numerous occasions pushing people in wheelchairs with no footplates attached, leaving their feet dragging on the floor, which had the potential to cause injury. A relative confirmed this stating, "Staff told me when they were pushing my [Person] in their wheelchair they lent over and grazed their face."
• People's care plans and protocols for medicines did not have enough information to support staff on when to administer as required medicines (PRN), particularly medicines to relieve anxiety, pain and constipation. The service had no pain assessment tools in use to enable people to communicate the type and level of pain they had. One person told us, "Staff don't give me pain killers, I have told them several times, walking is painful."
• Arrangements for reviewing and investigating safety incidents and events when things go wrong was poor. The senior management team had failed to systematically review bruising or skin tears to check for any themes and trends that may be safety-related.
• There was no formal system or process in place that ensured each safeguarding concern, complaint or incidents, such as injuries from falls were investigated to ensure action was taken to remedy the situation, protect people, prevent reoccurrence and make sure lessons were learned and improvements made as a result.

Systems and processes in place to ensure that people received safe care and treatment were poor and this meant people were at risk of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed action had been taken to purchase new profiling beds, all combustible items from unused rooms and airing cupboards had been removed, and hot and cold-water pipes had been insulated. A full audit of risk assessments, including PEEP's was to be undertaken to ensure they were robust. Night staffing levels had been increased to four staff to ensure people's safety at night in the event of a fire.

Staffing and recruitment
• People and their relatives told us there was not enough staff. Comments included, "Certainly not enough staff, they are too busy in the morning," and "Not enough staff, right across the board but worse in the morning and afternoon."
• The registered manager told us they had recently reviewed staffing levels due to the reduced number of people living in the service. However, people and their relatives told us there were not enough staff deployed to provide the right level of care and ensure people's safety and dignity.
• People told us that staff responses to call buzzers was often slow which placed them at risk of harm. This included people being unable to get to the toilet, resulting in incontinence. This was not only undignified practice, but increased people's risk of skin damage. Comments included, "I don't think staff answer 'buzzers' very quickly, for example I buzzed, but no one came, I spoke to the carer who said it was a busy time (lunchtime)" and "The other night I wanted to go to bed, and needed the toilet, I had to wait two hours, as they were putting other people to bed."
• People told us, staffing numbers and response to call bells was worse at weekends and at night. One person told us, "It is hit and miss at night, and night times at the weekend are slower."
• Some people had specific health conditions that required quick staff intervention to support them. Being left for long periods when they needed help increased the risk of harm. Staff told us they did not have time to give people the care and support they needed. Comments included, "I think we could do with more staff, "and "We can manage, but it would be lovely to have more staff as we are stretched. We do as much as can,

but it would be lovely to be able to sit for an hour and natter, it's the same at weekends."
• The recruitment and selection process in place ensured permanent staff recruited had the right skills and experience and were suitable to work with people who used the service.

Failure to have sufficient staff deployed across the service has left people waiting long periods of time to have their care needs met and placed them at risk of harm. This is a breach of regulation 18 Health and Social Care (Regulated Activities) Regulations 2014

The provider responded immediately after the inspection. They confirmed a review staffing levels considering people's dependency and the layout of the service was to be undertaken.

Preventing and controlling infection
• Systems for cleaning and disinfection of items, such as commodes, were not being carried out in line with nationally recognised guidance, such as Department of Health Code of Practice on Prevention and Control of Infections and related guidance. There were no sluice facilities or equivalent for the emptying cleaning and disinfecting of commodes and no cleaning schedule. Staff were unable to demonstrate that commodes had a weekly deep clean to reduce the risk of cross contamination.
• Arrangements for making sure the premises were clean and hygienic were insufficient to keep people protected from the risk of infection. We found, strong odours in various parts of the premises, toilet seats and lids stained, soiled pads left on furniture and in people's waste paper bins in their rooms, and people's underwear left in communal bathrooms. Relative's comments included, "My [Person's] room does not seem to be very clean in my eyes, and sometimes smells of urine," and "[Persons] room smells today of urine, it smells quite often, they [staff] should clean it regardless of whether they want it cleaned or not, it does smell."
• Mattress checking and cleaning schedules were ineffective. We found two people's mattress under protective covering heavily stained, soiled and offensive smelling of urine.

Infection control was poorly managed which placed people, staff and others at risk due to cross infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed action had been taken to purchase two electrically operated sluice machines to be installed.

Using medicines safely
• People's medicines, including controlled drugs were ordered, stored, administered and disposed of safely and in accordance with relevant best practice guidance.
• Random sampling of people's routine medicines tallied with records confirming they were receiving their medicines as prescribed by their GP.
• Systems were in place to detect errors and take prompt action if any errors were found.
• Staff responsible for administering medicines had received the appropriate training. Systems were in place to check their practice and competency.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's physical, mental health and social needs had been assessed on admission to the service, however their care, treatment and support was not being delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes.
• Most people living at Blenheim Care Home were at various stages of their dementia ranging from early onset to advanced stages. Whilst staff had completed online training that gave them a basic introduction into dementia, this had not given them the skills to support people with advancing dementia. As a result, we saw shortfalls in the care and support provided and outcomes for people, in particular those effected by the wider aspects of dementia including communication, unsettled behaviours and dysphagia (difficulty swallowing).

Staff support: induction, training, skills and experience
• Staff told us they had received training to ensure they had the skills and knowledge to meet people's specific needs. However, there was no system in place to assess staff's knowledge and understanding of training delivered and their competency to deliver safe and effective care. For example, staff told us they had completed safeguarding training and moving and handling, but had failed to report unexplained bruising, and were observed carrying out unsafe practice when supporting people to move.
• The staff member responsible for maintaining the premises was not provided with training or instructions to carry out health and safety checks in the service. Therefore, safety checks, such as legionella testing, fire safety and equipment were not comprehensive enough or based on nationally recognised health and safety requirements to ensure people's safety.
• New staff told us, and records confirmed they completed an induction when they joined the service, which included shadowing experienced staff. However, two agency staff had been recruited via an external agency and were living on site. One had no previous care experience and had completed in access of 20 pieces of training in one week. They had been included in the staff numbers, within two days of arriving at the service. The registered manager had not checked the agency staff was competent and safe to work with people using the service. The registered manager and nominated individual lacked understanding of their legal responsibilities for checking these agency staff were trained, skilled and competent before working with vulnerable people.

Failure to ensure staff were suitably qualified, competent, skilled and experienced to carry out their roles and responsibilities placed people using the service at risk of harm and receiving poor care. This was a

breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• The layout and decoration of the premises was not conducive to the needs of people living with dementia. The flooring throughout the lounge and dining area had started to lift in places increasing the risk of people falling and injuring themselves.
• Black and yellow hazard tape had been stuck over a significant area of the flooring. Not only did this look unsightly, changes in the colour of the floor and stripes or strong patterns can be confusing and disorientating to people with dementia.
• Where the premises had been adapted to facilitate wheelchair users, the flooring in places had steep slopes, the signage for these were far above head height, and would not be visible to warn a person using a wheelchair to mobilise.
• The premises lacked visual clues and items such as pictures, photographs or labels to help people with impaired vison, or confusion due to their dementia to find their way around the building. Some consideration had been given to installing blue toilet seats, lids and hand rails in an assisted bathroom, so they were easier for people to see, however this was not consistent throughout the building.
• People with dementia are often restless and like to have something to keep them occupied. There was a lack of tactile items around the service for people to hold, such as dementia muffs, hats, scarfs or other items of interest.

The premises have not been designed or maintained to a good standard to ensure it is safe and suitable for people who live there. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed a full environmental audit was to be undertaken to identify improvements need and damaged furniture.

Ensuring consent to care and treatment in line with law and guidance
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 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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

• People's care records contained information on how staff supported them to make day to day decisions, and the measures in place where decisions were taken in people's best interests. However, we found one person's risk assessment for their profiling bed (a bed electrically operated using a remote to assist elderly and, or disabled person with mobility) stated, 'staff position bed and keep remote in safe place as [Person] could activate bed and injure themselves.' This practice prevented the person from being able to reposition themselves from lying flat to an upright position. Their care records showed they had been assessed as not having capacity to make decisions about their care, however there was no MCA assessment in place to reflect this restriction had been agreed in their best interests. Neither did their DoLS assessment include this restriction.

We recommend the provider considers seeking advice from a reputable source, such as the local authority adult safeguarding board to ensure decision making where people are deemed to lack capacity is made in accordance with The Mental Capacity Act 2005 (MCA) legal framework.

• Where people had been deemed to lack capacity to make more significant decisions about their health, welfare and finances, relevant people including their Lasting Power of Attorney and health professionals had been involved.
• Routine DoLS applications had been made where needed. A matrix was in place to monitor authorisations and expiry dates.

Supporting people to eat and drink enough to maintain a balanced diet
• People and their relatives told us the quality of the meals provided was good. Comments included, "Food is excellent, the roast pork was better than I expected, they are very good on drinks," and "Good meals here, fed well, home cooked dinners, they have fruit like banana's for elevenses." One person told us, "I can choose from a variety of options, such as jacket potato and cheese, and lasagne, and I'm always kept supplied with drinks."
• People at risk of weight loss were provided with nourishing drinks such as milk shakes to improve their nutritional intake.
• Although people were positive about the food, we saw mealtimes were task led, rushed and not a social experience for people. Where people needed support to eat, staff did not stay with the same person the entire time, they moved from one person to another, and on occasion with little engagement.
• Staff told us adapted crockery and cutlery was available to help people eat more independently, however we saw these were not provided. People struggled to cut up their food and were seen using their fingers to eat or left their meal to go cold.

Staff working with other agencies to provide consistent, effective, timely care
• The service has had a significant amount of support from the local authority quality monitoring team who have had oversight of people's health and welfare and prompted staff to make referrals to relevant healthcare professionals, where needed.
• Despite this support, where referrals had been made, people's care plans were not routinely updated following health professionals' input and failed to provide staff with information about changes to people's care, or treatment. For example, a person at risk of choking had been assessed by the speech and language therapist, however a change about the texture of their food had not been updated in their care records, which meant they remained at risk of choking.
• However, people, and their relatives told us staff worked well with professionals. One person told us, "I was admitted to hospital last week with a chest infection, I was unconscious, and staff called the paramedics. The staff handled it brilliantly, they were out of this world, liaising with the paramedics and staying with me until they came."
• Where people were at risk of poor nutrition and/or unplanned weight loss staff had consulted with the right healthcare professionals, such as the speech and language therapist and dietician for further support and advice.
• We spoke with three visiting health professionals who provided positive feedback about the service. Comments included, "It is good, excellent manager, got no problems, flexible staff very helpful, no problems with referrals, never had a problem here," and "We have a good working relationship with staff, they are knowledgeable and ask questions. They are good at referring people to us when they have concerns about their health."

Supporting people to live healthier lives, access healthcare services and support
• The registered manager provided poor leadership and failed to recognise the associated risks to people's

health being sat in the same chair all day, without meeting their continence needs, such as increased risk of urinary tract infections and pressure wounds developing. They were unable to tell us, how many people had existing pressure wounds or were at risk of these developing.

• However, people told us, they were supported to manage their health conditions. One person commented, "If my blood sugar goes down staff get me something to eat, like soup, drinks, Lucozade, or sandwiches, never a problem they are very good on that."

• People were supported to see their GP, and health professionals when needed. Relatives commented, "We [family] are kept informed by phone, our [Person] has a chest infection, they were supported to see the GP. We have no concerns on being kept up to date." Other comments included, "They always ring me if the doctor has been, we are always aware if [Person] has an infection, communication is very good, always known before I come in if something is wrong," and "My [Person] had a really bad chest last week, and became really poorly and had to go to hospital. Staff rang to tell me they had got the doctor out and informed me they had a chest infection. The staff have been really great, even those not on shift have been messaging me, they really are caring."

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
• There was a lack of leadership and guidance for staff to ensure they were aware of and understood the principles of providing person centred care.
• Staff were observed being kind to people, however the care delivered was intuitive and not driven by best practice. People with more complex and/or latter stage of dementia related needs were left seated in lounges for extended periods of time, with little or no interaction or stimulation.
• We saw there was a culture of getting people up early in the morning to fit into the staff's daily routine, irrespective of peoples' choice and preferences. Both days of the inspection, day one at 9am and day two at 8am, 20 people were up, dressed and seated in the lounge, disengaged or sleeping. Staff told us this was normal practice. One person told us, "I get up 7 to 7.30, that is about right, they come to get me up, it is not part of the game to stay in bed, they do like people to be up." Another person commented, "They [staff] got me up an hour or two before I wanted to get up, I wanted to stay in bed".
• People told us they were not always treated well, were ignored or left in pain. One person told us, "They [staff] ignore me because I won't go down stairs, I cannot as I have a bad knee, I cannot walk properly, sometimes they take me, they keep saying you have got to come downstairs, I cry sometimes with the pain."
• The providers website states Blenheim Care Home strives to provide high quality, person centred care tailored to people's needs where promotion of independence, dignity and individuality is a priority. However, we found people's privacy and dignity was not promoted.
• People were left in an unhygienic and undignified manner before they were supported with their toileting needs. Throughout both days of the inspection, inspectors observed people were not frequently offered or supported to go to the toilet except for those who were able to ask.
• Over both days we saw people were taken to the toilet only once. The smell of urine in the larger lounge became stronger throughout the day. People's clothing was wet; therefore, it was evident their continence needs were not being met. One person told us, "Sometimes staff are a while coming, both day and night. I get a bit moody if I can't go to the toilet. I had an accident, they said that I should not do it, but it was an accident, I did not feel so good when they said that."
• Staff were focused on completing care-based routines and did not have the time to spend with people to make them feel they mattered. Staff failed to anticipate people's needs, distress and discomfort at the earliest stages. This included the failure to support a person suffering with depression and supporting people at times of distress. One person told us, "I have seen people wait for quite a long time waiting for the

toilet, they are crying out."
• Respect for people's dignity was not embedded in the service. People's bedrooms were sparse, divan beds were old and unstable. Beds had been made using thin sheets, threadbare blankets and lumpy pillows, despite having a lot of new duvets stored in a cupboard.

People using the service were not treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to make day to day decisions about what they wanted to eat, however we saw people's choices about where they wanted to sit, when they wanted to go to the toilet or when they wanted to get up and go to bed were not promoted.
• Care plans outlined family involvement in planning their relatives care, including consenting to care and treatment where their relative was deemed not to have capacity to make those decisions.
• Where needed people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions in place, which set out their wishes or a decision made on their behalf by a medical doctor in discussion with relevant family members that in the event of a cardiac arrest they were not to be resuscitated. They had been signed appropriately by the right people.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People's care and support was not planned and delivered in an individualised or personalised way. People were not involved in planning, developing and monitoring their care to make sure it met their needs.
• Care plans lacked up to date, relevant and personalised assessments to guide staff on how to effectively deliver care to meet their needs. For example, where people were at risk of developing pressure wounds care plans contained no detail of the frequency the person should be repositioned, or how frequently their continence products were to be checked and changed.
• People at risk of choking did not have care plans that provided clear guidance to staff on how to manage and reduce this risk.
• Many people living at Blenheim House were at various stages of their dementia ranging from early onset to advanced stages. Significant and relevant information about people's background and life stories, individual preferences, interests and aspirations had not been obtained and used to inform their care plans to guide staff on how to support them in the most effective way
• Care plans did not reflect how people's dementia, mental health or long-term health conditions impacted on their day to day living, or the support they needed to manage this aspect of their care.
• Peoples oral health had been assessed, however there was limited information in care plans on how this aspect of their care was to be met. We found people were not receiving adequate mouthcare. People did not have denture pots to soak and store dentures overnight. No toothpaste was found in people's rooms, and there were no signs that toothbrushes had been used.

Failure to develop clear care and treatment plans meant people were not receiving the personalised care needed to meet their specific needs. This is breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection confirming a full audit of people care plans was to be undertaken to ensure they accurately reflected people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People and their relatives told us activities were provided to help people maintain their hobbies and interests. One person told us, "I sit and knit, it is my favourite hobby." Relatives comments included, "It is good, they encourage people to do activities to try to keep them alert. They have done flower arranging,

chair exercise and played bingo. They also have entertainers and singers come in," and "The activities co-ordinator uses sensory things from the garden, such as cut grass, roses and lavender to engage with people, they get them to guess what they are. They have good entertainment including panto, all the residents love that and the care staff interact too."
• The activities coordinator showed us photographs of such events, however during both days of the inspection we saw activity provision was poor and not at a level, which met people's individual needs.
• People lacked meaningful interaction or stimulation and remained seated in both lounges all day asleep, disengaged or not wanting to communicate with others.
• Keeping active and engaged can really improve people's quality of life, so making sure they can still enjoy doing their favourite things and stay in contact with people is important. The activities person was trying to engage people in a game of bingo with the TV still on, which made it difficult for people to hear. Other activities were attempted, with limited participation due to the seating arrangements, which did not encourage people to get involved.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The registered manager had implemented some processes to meet these requirements, such as providing information about the service, how to complain and menus in large type, however they needed to do more to meet the information and communication needs of people with dementia, and sensory loss.
• Staff did not know how to support the sensory side of an activity for people in mid to late stages of dementia, who had lost the ability communicate.

End of life care and support
• The registered manager told us they used the services of local palliative care specialists to provide training to staff to ensure they were competent in the care of terminally ill people.
• Relatives praised the registered manager and staff for the care their family members had received at the end of their life. Comments included, "Thank you for all the care and kindness you gave my [Person]," and "We can't thank you enough for all the love and kindness you showed [Person], nothing was too much trouble, we were touched by all the love the staff showed when they passed away."
• The registered manager told us they were working with the hospice, who had arranged for the service to work towards accreditation of the Gold Standards Framework (GSF). GSF is a framework used by many GP practices, care homes and hospitals to enable earlier recognition of people with life-limiting conditions, helping them to plan to live as well as possible right to the end.
• A review of people's care plans showed advanced care planning was in varying stages. Some had completed Preferred Priorities of Care (PPC) in place detailing people's preferences for their end of life care. However, others were in development, or had no information about the persons end of life wishes.

Improving care quality in response to complaints or concerns
• Systems were in place to acknowledge and respond to complaints. One person told us, "I have no complaints, I would talk to the manager, they are very nice and very helpful."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care
• There was a registered manager in post, supported by a regional manager, who was also the nominated individual.
• The registered manager and nominated individual were unable to demonstrate how they assured themselves the service was safe, and people were receiving appropriate care. Although, both had carried out audits of the service, these were ineffective as they had not identified, captured and managed risks to ensure people received care and treatment in a safe way.
• Neither the registered manager or nominated individual understood how to analyse information obtained from audits to look for trends, themes or root causes of incidents that had occurred.
• Systems for checking the safety of equipment were ineffective and therefore risks to people's safety had not been identified and acted upon. Beds, mattresses and bed rail checks had not identified ill-fitting bed rails and mattresses were non-compliant with health and safety standards. This exposed people to a significant risk of injury, and death by entrapment and suffocation.
• Although, the nominated individual took immediate action following the inspection to address the areas of risk we identified in relation to incompatible bedrails and mattresses, the quality monitoring systems in place had failed to identify and mitigate the risks.
• Systems and processes for protecting people were not well established or being used effectively by senior management or staff. The arrangements for reviewing, investigating and learning from safety events was poor.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Staff told us they worked in accordance with the providers values for the service in line with the 6C's. These are a set of values which underpin 'Compassion in Practice', part of a national strategy for nurses, midwives and care staff, launched in December 2012. The 6C's are care, compassion, courage, communication, commitment and competence. However, the care delivery we observed was not in line with these principles.

• Staff told us, "We get on really well, we all seem to gel and communicate well, it is like a little family here. Staff morale is down, we work hard, try really hard but constantly being told by other professionals we are

not good enough." We found the registered manager had not ensured the service was run in a manner that promoted a caring and respectful culture. They failed to ensure staff had the appropriate knowledge to understand the needs of people and how they should be properly cared for.
• Staff told us the registered manager was approachable. Comments included, "Yes, approachable if have a problem and helpful," and "The manager and deputy provide good leadership and direction. I think they are good at job they will tell me if I need to do something." However, we found staff lacked leadership and guidance on what good dementia care looked like, which resulted in people not receiving the care and support they needed to say well and engaged.
• The registered manager failed to have the right level of scrutiny and oversight of the service. We found significant shortfalls as shown throughout this report about the standard of care, unsafe use of equipment, issues around mealtimes, the environment, poor bedding, loose and damaged wires, mattresses not clean and the impact of too few staff.
• The nominated individual regularly visited the service, however their audits had also not identified or responded robustly to poor care practice and shortfalls in the service.

Due to poor governance and lack of managerial oversight of the service people were placed at risk of harm. This is breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff told us, and records showed they attended monthly staff meetings where relevant issues were discussed including feedback following recent visits from the local authority.
• People had been asked to complete a recent 'Service User Questionnaire' to obtain their feedback on the quality of the service. These questionnaires had been completed in February 2020, and the findings had not yet been analysed. People were asked if they were happy at the service, if their needs were met, about the meals, and if staff close at hand to help. Comments were mostly positive, however most people stated they was not always enough choice around meals and not enough staff available to meet their needs.

Working in partnership with others
• The registered provider has worked well with the Commission following the findings of the inspection. They have responded in full to the possible urgent enforcement action letter sent to them after the inspection with regards to the poor care practice and shortfalls we found.
• The service had also worked well with the local authority in an open and honest way to make improvements to the service.