Bluewater Care Homes Limited

Bluewater Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Bluewater Nursing Home is a residential care home providing personal care to 22 people aged 65 and over at the time of the inspection. Some people were living with dementia. The service can support up to 60 people. Although it is called a 'nursing home', it does not provide nursing care. The home is based on four floors with an interconnecting passenger lift. The ground floor provides communal areas for people and the first, second and third floor provide bedrooms, communal bathrooms and a small communal area. Only the ground and first floors were in use at the time of the inspection.

People's experience of using this service and what we found
This inspection was undertaken because since our inspection in March and April 2021 we had received numerous concerns from a variety of sources. These concerns related to the management of risk and the management of medicines for people.

At this inspection whilst people did not tell us they felt unsafe, we found ongoing concerns regarding the management of choking risk, skin integrity, falls, behaviours and constipation. Staff lacked an understanding of the needs of people and we were not assured people received the support they required to keep them safe at all times. We found ongoing concerns regarding the management of medicines and people were not receiving their medicines in line with their prescriptions.

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 inadequate (published 19 May 2021).

Why we inspected
The inspection was prompted due to concerns received about the safe care and treatment for people and the management of medicines. We undertook this targeted inspection to inspect and examine those risks. The overall rating for the service has not changed following this targeted inspection and remains inadequate and in special measures.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We have found evidence that the provider needs to make improvements and there is an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Please see the Safe section of this report.

We asked the manager to take immediate action to address our concerns about the management of choking risks and medicines. The manager told us what action they would be taking, and we sent us some evidence of this. We also referred these concerns to the local authority responsible for safeguarding people.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bluewater Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified an ongoing breach in relation to safe care and treatment and medicines management at this inspection.

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
At the time of this inspection the service was receiving input and support from a number of health and social care professionals to make improvements needed as a result of our previous inspection and safeguarding enquiries. We will continue to liaise with the provider and all relevant agencies already involved in supporting the service. This will inform our ongoing monitoring of the service until we return to visit. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Bluewater Nursing Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to inspect and examine concerns we had received regarding safe care and treatment and medicines management. The overall rating for the service has not changed following this targeted inspection and remains inadequate and in special measures.

Inspection team
The inspection team consisted of four inspectors.

Service and service type
Bluewater Nursing 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. After the last inspection the registered manager cancelled their registration and a new manager started. However, that new manager left approximately eight weeks later. The previous registered manager was working as the acting manager at the time of this inspection visit. We refer to this person as the manager throughout the report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We 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.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with six members of staff, the director, the nominated individual and the manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

People were not always able to speak with us in depth about the care they received so we spent time observing the support and interactions between people and staff. We also reviewed the environment and equipment in place.

We reviewed a range of records. This included six people's care records and multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who visited the service.

Inspected but not rated

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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

This was a targeted inspection to inspect and examine concerns we had received regarding safe care and treatment and medicines management. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management; Using medicines safely
At the last inspection we found the provider had failed to ensure the safe care and treatment of people. Risks to people were not always assessed and where assessments were in place, we were not assured staff understood or adhered to these. Medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found insufficient improvement had been made and the registered provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection we have received ongoing concerns about the safety of people. Concerns raised to CQC included but were not limited to the management of choking risks; the management of bowels; the management of skin integrity; the management of behaviours; the management of falls and the management of medicines.
● At the time of our inspection the service was receiving input and support from a number of health and social care professionals to make improvements needed as a result of our previous inspection and safeguarding enquiries.
● Prior to this inspection the provider submitted information to CQC which stated that, 'All care plans (sic) have been reviewed and updated to reflect current care.' Whilst we found this had been completed in some areas for some people, we continued to find concerns. For example, at the last inspection we identified that one person living with diabetes had no plan in place informing staff of how this may affect them and what they should monitor for. We continued to find no plan in place for this person regarding their diabetes. One member of staff told us this person was diabetic but no longer thought they were since their medicines stopped, whereas the manager told us although the paperwork said they were diabetic the person was not. We spoke to an external health professional regarding this person. They told us the person has a formal diagnosis of diabetes, that this was diet controlled and that they have never been prescribed medicines for this condition. This demonstrated a lack of knowledge and awareness by staff and the manager of the person's health risks.
● At the last inspection we found that meal records for this person did not reflect they were regularly offered meals, which would be important in helping to manage their diabetes. At this inspection the records of meals offered continued to contain gaps and we could not be assured of the meals they were offered.
● At our last two inspections we found concerns about the management of choking risks. Following the last

inspection, the registered manager sent us an action plan stating this information would be incorporated into care plans by 31 May 2021. Although assessments for the risk of choking had been completed, care plans lacked clear guidance to staff about what support people required. They contained no information about how a choking episode may present or the action staff should take if a person did choke. Staff were unable to tell us about all the people who needed to be given a soft bite sized diet and people at risk pf choking, food records stated their meals had been prepared to a regular consistency on a regular basis. At this inspection the manager provided us with an action plan stating the target date to complete this work was the 5 July 2021.

● At this inspection we found these concerns remained. For one person their risk assessment stated they were at risk of choking and that they required a texture modified diet, however the care plan did not contain this information. Records of meals provided showed, that at times they were given, 'food prepared to a regular texture.' When we asked staff about how this person meals should be prepared one told us, 'I think she is on bite sized, but not 100% sure" and a second told us they were on a soft diet but then described how the person is at risk due to certain sweets bought in by the family. They told us they remove the sweets when the family are not present but return them when the family visit. These staff practices place the person at risk of choking. We informed the manager and asked them to take immediate action.

● We found that the meal records for a further two people recorded that at times their meals were prepared to the wrong consistency and that they were given food items that were high choking risk. The director told us that when staff recorded 'regular', this was regular for that person. Staff told us they recorded the actual texture of diet that was provided. However, we highlighted that they do at time record the correct texture. Staff's knowledge and understanding of the type of textured diet people should be provided with varied and they were not all able to consistently explain what people should be receiving. This placed people at risk of not always receiving appropriate food to minimise their risk of choking.

● We asked the director and manager to take immediate action to address the concerns we had identified in relation to the management of people's choking risks. They told us they had begun discussions with individual staff members, would hold a team meeting the week after the inspection, put up signs in people's rooms who were at risk, introduce a crib sheet for staff to carry which contained key information about risks, revise the information in the kitchen and arrange external training. They then sent us a photo of the information on the kitchen wall, which they said would be sent to all staff members. They also sent us a sample of the information they confirmed had been put into people's rooms.

● At the last inspection we found people at risk of constipation had not had this risk incorporated into the care plans and staff were unaware of the risk. In addition to this we found where people at risk had not had a bowel movement for prolonged periods of time, no action had been taken to address this and they were not being administered their medicines to help prevent constipation.

● At this inspection we found the risk had been included in care plans, but it was not always clear what the staff should do if the person had not had a bowel movement. For example, for one person their care plan stated they were at risk of constipation and took laxatives daily. The records contained no information about when staff should act if the person had not had a bowel movement. Bowel monitoring records for this person recorded no bowel movement between 2 and 8 July 2021. This person medicine administration record (MAR) showed they had been administered their prescribed daily medicines only on two occasions in this period. This medicine was prescribed to be given twice a day. When we pointed this out to a senior member of staff, they told us, "It will be brought to supervision and we are training anyway." They confirmed that this issue had not been raised with staff and they believed that the person was refusing the medicines, but staff were using the wrong recording code. They asked a member of staff who administered medicines and this member of staff said, "No [they] have it PRN (as required), [they] will take it when it is offered if [they] want it" and "I thought it was PRN."

● We noted that the MAR stated this medicine was to be given PRN, however, the prescription was clear this should be given twice a day. We were concerned that this issue had been highlighted to the service by

external health professionals. External health professionals confirmed they raised this on 25/6/2021 and emailed the concerns to the manager on 28/6/2021. A note was in the staff communication book dated 30/6/2021, highlighting the need to follow the prescription (label on box or bottle) and not the MARS. The manager told us they would be moving to a paper-based medicines administration recording system the week after our visit due to the incorrect recording of medicines. It was evident staff were either unaware or choosing not to adhere to the external professionals' concerns and that management had not followed up to ensure practice had changed, until the new recording system was implemented. This placed this person at risk of not receiving their medicines as prescribed.

● At the last inspection we found concerns about the management of people's skin integrity. For two people we saw their assessment tools reflected they were at very high risk of skin breakdown and their care plans stated they were cared for using air mattresses. We observed these were not in place and were stored in the dining room. We asked the manager why these mattresses had been removed and they said they thought this was a decision by external professionals when the previous manager was in post. Following the inspection, we discussed this with the external professional who confirmed the decision to remove these was not made by them. They confirmed they had visited the service since our inspection visit and told the staff to reintroduce appropriate pressure relieving equipment. For one of these people their care plan stated they were to be supported to regularly change position. However, three of four staff members told us they did not receive support to be repositioned. Records showed this person was sat in their chair for prolonged periods of time with no change of position which would help prevent pressure sores. This person had previously sustained a pressure injury in May 2021.

● At the last inspection we found concerns regarding the management of falls because staff were not adhering to falls risk assessments and where equipment was listed in care records this was not always in place. At this inspection we continued to find these concerns. Following falls, the protocol stated that certain observations were required, including a check on the person blood pressure and pulse. However, we did not see this consistently happened. At the last inspection the manager introduced a post fall checklist due to this issue but at this inspection we found no completed records and two members of staff told us they had not seen any completed. The manager told us they were not sure if the previous manager had continued the use of these, however we did see the blank record on the wall of the staff office. For one person their care records stated a sensor alarm was to be used. We did not see this in place when we first arrived but did see it being used later in the day. For a second person their care plan stated crash mats should be in place, but we observed these were not which placed them at risk of injury as staff would not know when they were mobile and required assistance .

● At the last inspection we found people's medicines were not always managed safely. Since the inspection the Clinical Commission Group had audited the service and identified several concerns including people not receiving their prescribed medicines. The concerns were shared with the service on 25/6/21 and 28/6/21 but we found a number of people had not received their medicines in line with their prescription. One of the errors contributing to this was the MAR sheets which inaccurately recorded some of the medicines as PRN. However, the prescription on boxes and bottles was accurate and staff had been informed to follow the prescription and not the MAR. However, we observed a member of staff enter the medicines room and dispense a medicine for one person without checking the prescription on the box.

● We also found a number of medicines in use which contained no date of opening. This is important because the liquid medicines had specific instructions for when they should be discarded. When we discussed this with a senior member of staff, they added a date to these medicines stating they could tell from the new cycle when it was opened because all medicines were replaced each new cycle. We saw no evidence to confirm this.

● We asked the senior member of staff what audits or checks take place of medicines and were told the senior member of staff carry out a full count every month and the staff do a count of three random people every day but there were no record of the staff checks.

● Despite these checks, medicines errors identified above and previously identified by the CCG team were not being identified by the service.
● Following the inspection, we discussed our concerns with the CCG medicines team who explained they were visiting the week after our inspection visit and would follow up on these. We asked the manager what action they would be taking to ensure people received their medicines in line with their prescription over the weekend and they told us they would be overseeing all the medicines rounds.

The ongoing failure to ensure medicines were managed safely and the care people received did not place them at risk was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we referred our concerns about the management of choking risks and medicines to the local authority.