Bluewater Care Homes Limited

Bluewater Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The first day of inspection took place on 31 October 2017 and was unannounced. Following this day of inspection we received notifications about two safety incidents during which a person using the service sustained a serious injury and another where a person died. These incidents are subject to a separate investigation. However, the safeguarding investigation shared with the CQC about the incident relating to the serious injury substantiated that appropriate medical attention had not been promptly sought. On 4 December 2017 two inspectors undertook a further day of unannounced inspection to review risks related to this concern and follow-up on information from the first day of the inspection.

Bluewater Nursing Home provides accommodation and personal care for up to 60 people, the service does not provide nursing care. There were 19 people living at the home when we visited. The service also provided some day care and on the second day of the inspection two people were receiving a day care service. The service was operating at approximately one third occupancy during the inspection. People were all accommodated on the first floor of the home. All areas of the home were accessible via a passenger lift and there were communal areas on the ground floor. There was an accessible outdoor courtyard garden.

Bluewater Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. We found the home to be clean and tidy throughout the inspection.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Since 2015 all comprehensive inspections of the service have resulted in Inadequate or Requires Improvement ratings.

The last comprehensive inspection of this service was in October 2016 when the service was rated Requires Improvement; we found three regulatory breaches. In July 2017 we undertook a focused inspection to check on these breaches and found sufficient improvements had been made

At this comprehensive inspection we found five breaches of regulations. This was within six months of the focused inspection in July 2017; this demonstrated that the provider of this service was unable to sustain improvement in the long term. There were systemic failings identified during this inspection which had already been identified at the last three comprehensive inspections of the service. All three regulatory breaches from the last comprehensive inspection in October 2016 were repeated. Failures to provide safe and care and treatment, person centred care, good governance and failing to act in accordance with the Mental Capacity Act 2005 were common themes.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Quality and safety monitoring systems were ineffective in identifying and directing the service to act upon and mitigate risks to people who used the service and ensure the quality of service provision.

Care plans were not consistently person centred and lacked detailed guidance for staff to ensure people received care in a safe way. Risk assessments that related to peoples health and safety did not ensure that all risks were effectively assessed. Action had not always been taken to reduce identified risks to ensure the safety of people. This exposed people to a risk of neglect and unsafe or inappropriate care or treatment.

Records relating to the management of the service had not been effectively reviewed and assessed; we found errors, omissions and discrepancies that had not been identified by the registered manager's quality assurance systems.

The administration, safe management and security of medicines was not in line with best practice. Medicine administration records did not confirm that people had received all medicines as prescribed. There was a lack of guidance for staff to support people with medicines and PRN (as required) medicines were not effectively recorded or monitored for effectiveness. .

Records of the assessment of people's ability to make some informed decisions had been undertaken. However records did not show that the principles of the Mental Capacity Act 2005 were being applied in respect of best interest decisions to provide care or use restrictive practices. Staff we spoke with had a variable understanding of the Mental Capacity Act 2005.

Staff received training; however records were unclear as to what training each staff member had received. Staff had not received regular and meaningful supervision. The provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views.

People we were able to speak with said they felt safe. Staff said they knew how to prevent and report abuse. We were concerned however that staff practice which amounted to omissions of care had not been considered as neglect by them or the registered manager.

Staffing was not planned effectively. There were not enough staff to meet more than people's basic personal care needs; staff were task orientated and did not spend one to one time with people.

Peoples' wellbeing was not promoted due to a lack of person centred activities. We observed and people told us that activities were limited and did not take place as per the advertised schedule of activities.

We received some positive feedback about the care staff and their approach with people using the service; however we observed occasions when people's dignity had been compromised.

Staff said they worked well together and that this created a relaxed and happy atmosphere that was reflected in people's care. Our observations however did not always find this to be the case particularly when people's needs were ignored by staff.

People and some external health professionals we spoke with were positive about the service people received and people's visitors were welcomed. However not all external stakeholders we spoke with felt that the provider engaged with them positively.

People had access to healthcare services. People were positive about meals and they were supported to eat and drink when required. However records used to monitor peoples' fluid intake were not always completed with the correct intake; this had not been identified by reviews of records. This exposed people to the risk of dehydration.

There was a complaints policy in place. People and relatives knew how to raise concerns; however there was no process to record informal complaints.

People were encouraged to maintain relationships that were important to them. Bluewater Nursing Home was animal friendly and people were able to bring their pets with them when they moved in.

Appropriate recruitment procedures were in place and pre-employment checks were completed before staff started working with people.

Plans were in place to deal with foreseeable emergencies such as fire risk; staff we spoke with said they had had received training to manage such situations safely.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

Risk assessments that related to peoples health and safety did not ensure that all risks were effectively and competently assessed. Action had not always been taken to reduce risks to ensure the safety of people.

Medicines were not managed safely.

Staffing was not planned effectively .Staff were task orientated and did not meet more than people's basic personal care needs.

Staff knew how to report abuse. We found however that staff may not always be able to identify omissions of care that may amount to neglect.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked the ability to make decisions, such as those relating to care, best interest meetings or discussions had not been recorded.

Staff performance was not monitored effectively as regular, meaningful supervisions had not taken place. Staff received training; however records were unclear as to what training each staff member had received.

People received a varied diet and were supported appropriately to eat. However people's fluid intake was not monitored effectively.

Where necessary Deprivation of Liberty Safeguards (DoLS) applications had been made.

The environment was suited to the needs of people living there; however, for some people living with dementia the amount and type of decoration may prove overwhelming and confusing.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for and treated with dignity, respect, kindness and compassion. On occasions staff ignored people's requests for assistance and confidentiality was not assured.

People who were able to speak with us and their relatives were positive about the way staff treated them.

People were supported to maintain valued relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans and care delivery was not consistently person centred.

People did not always receive adequate mental and physical stimulation or person centred activities.

There was a complaints policy in place. People and relatives knew how to raise concerns; however there was no process to record informal complaints.

Is the service well-led?

Inadequate

The service was not well led.

A quality assurance process was in place, however, this had not identified the areas of concerns we found. The provider had failed to ensure improvements were sustained over time.

External stakeholders gave variable feedback about their relationship with the service.

People and their relatives felt the home was well organised. Staff understood their roles and felt they, worked well as a team and were valued by the registered manager.

Bluewater Nursing Home

Detailed findings

Background to this inspection

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

This inspection commenced on 31 October 2017, was unannounced and undertaken by three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Following the inspection we received some additional information which was a concern. On 4 December 2017 two inspectors undertook a further day of unannounced inspection to review this concern and follow-up on information from the first day of the inspection.

Before the inspection, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the home; other people were unable to have a coherent conversation due to their living with dementia. We also spoke with one visitor and with members of the management team including the provider of the home the provider's nominated individual, the registered manager, five care staff and ancillary staff including, the cook and housekeeping staff. We also spoke with three visiting healthcare professionals and other external stakeholders. We looked at care plans and associated records for ten people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance. We observed care, support and activities being delivered in communal areas.

Inadequate

Is the service safe?

Our findings

Risk assessments that related to peoples health and safety did not ensure that all risks were effectively assessed. Action had not always been taken to reduce identified risks to ensure the safety of people. Some risks had not been assessed. This exposed people to risks of neglect and unsafe or inappropriate care or treatment.

Individual risks to people were not managed effectively. Staff did not have the correct guidance to manage all risks to people safely. This put people at risk of receiving unsafe and inappropriate care. Care plans we looked at contained a range of risk assessments that had been reviewed monthly. There was not however always enough detailed guidance provided for staff. For example, one person had been assessed as having a very high risk of falls. Their care plan detailed the reasons why the person was at risk but guidance for staff was limited to having the bed at a low position, having the call bell within reach and having a sensor mat in place. There was nothing documented in relation to the type of footwear the person needed, or whether they had a higher risk of falls at certain times of the day. We saw that the person's sensor mat was not always in a suitable position to detect that the person was moving around their bedroom. The registered manager told us the person moved the sensor mat out of the way therefore making it ineffective. However the registered manager had not re-assessed or considered alternative methods to address this risk, such as movement sensor alarms. On one occasion we found the person standing unsteady on their feet. The sensor mat was away from them and had not been activated. We assisted the person to sit down and called care staff. The failure to re-assess the risk in order to manage it effectively had placed the person at a continued high risk of falling

Shortly before the inspection an incident had occurred when one person had entered another person's bedroom and moved a hot drink within reach of a vulnerable person. The registered manager told us the first person, who was living with dementia, liked to be 'helpful' with other people. Their care plan identified this but a risk assessment had not been completed in respect of the risks they posed to more vulnerable people. The second person had been scalded by the drink and was requiring ongoing medical attention. To reduce the risk to the person a sensor mat was in use to alert staff that someone was entering the person's bedroom. However, we saw the sensor mat was not placed correctly as it had been moved to the side of the entrance way. We discussed this with care staff who said the mat was not effective as people could just step over it. We discussed this with the registered manager who said that a walking frame was usually placed in front of the sensor mat to act as a further deterrent to people entering the bedroom. This did not assure us that the registered manager was competently assessing risk as the use of a walking frame as a barrier to people entering a room posed additional falls risks to other people. During the inspection we saw that staff could not find this person who had been very unsettled and verbally abusive to other people.

Staff were unaware of the risks fluid thickener powder posed to people if eaten dry and not mixed with a drink. We saw a tin of fluid thickener with an easily removable plastic lid in an unlocked cupboard in an area of the home fully accessible to people. This exposed people to the risk of choking. The registered manager took action to ensure the thickener powder was stored securely. In both the care plan and medicines administration record for the person for whom the fluid thickener was prescribed there was no information

available as to the consistency of fluids the person should be receiving. Care staff did not have the required information to ensure the person received their fluid thickener safely. Care staff gave us inconsistent information as to how much fluid thickener they added to the person's drinks. This meant that staff had consistently been exposing the person to a risk of choking. We advised the registered manager of this and they sought to clarify to staff the consistency of fluid the person should be receiving.

Staff did not always ensure people's safety as they failed to apply risk management guidance effectively.

We saw a person, who had previously told us about some falls they had experienced, sitting in their bedroom in a wheelchair. The brakes had not been applied. We alerted a member of care staff who said "But he's going down for lunch." We said the person had been sat unattended in the wheelchair for at least five minutes with no brakes on. The staff member then took the person to lunch. The failure to correctly apply the brakes and leave the person unattended placed them at high risk of falling.

Another person had been assessed as at high risk of pressure injuries and their risk management plan was that a pressure relieving cushion should be used. We saw that they were not using this when seated in their bedroom chair throughout the inspection. In the afternoon we saw it had been left in their wheelchair and not transferred to the chair they were sitting on. The failure to follow the risk management guidance was placing the person at risk of developing a pressure related injury.

Staff failed to follow the guidance in a risk assessment relating to a kettle located in an area accessible to all people. The risk assessment specified that the kettle would be emptied and 'put away' when not in use. Throughout both days of the inspection, including times when no staff were in this area the kettle was left on the work top available for people to access and had not been emptied of hot water following use. This put people at risk of scalding.

People living with dementia were exposed to the risks of taking medicine that was not prescribed for them. One person who was self-administering their medicines, did not have their medicines locked away. We saw the person's medicines on the bedside table in their room. The provider's medicines management procedure stated that people who were self-administering medicines should have a locked storage space in their room. The person's risk assessment for self-administration of medicines also stated that medicines would be in a drawer when not in use. Staff said the medicines should have been in a locked drawer, but there was no key for the drawer in the person's room. The registered manager found the key and the medicines were subsequently locked away. This was particularly relevant because we saw another person who was living with dementia enter this person's room. The person whose room it was also told us about another person who was living with dementia who had entered their bedroom on a number of occasions. In two further bedrooms we saw a prescribed topical cream and prescribed eye drops which could be accessed by other people.

The registered manager had assessed the risks associated with the environment and the running of the home; these risk assessments were recorded along with actions identified to reduce those risks. However this had not identified all risks to people. For example, we saw a flight of stairs rising from the first floor near the communal area and accessible to all people a number of whom were walking about independently. We asked the registered manager for the risk assessment for these stairs. They were unable to provide this and stated they would complete the risk assessment.

Incidents and accidents were recorded and cross referenced to the care files of people involved in the incidents. We saw that preventative measures were also identified by the provider wherever possible in relation to these incidents. However, we found that the preventative measures were not implemented

effectively. For example, one person had fallen due to ill-fitting footwear; this had been identified and the person's family had been contacted to ask them to purchase suitable footwear. The person fell again ten days after the first fall and had been wearing the same ill-fitting footwear. New footwear had not been purchased and this had not been followed up with the person's family. In the meantime no measures had been undertaken to ensure the person was supported to choose other footwear for their own safety; this had exposed the person to a high risk of falling.

Following the first day of the inspection we were informed about an incident when a person received a head injury. We requested and received additional information from the registered manager. This information did not assure us as it did not answer all questions about how the incident was managed. We reviewed information from the person's care plan. The person's risk assessment stated they may behave in a way that causes them to self-inflict injuries to their head. We looked at records related to the incident; the person's body map recorded that they had received facial injuries from their actions. Staff at the time had sought support to manage the person's behaviour but not medical advice about the injury. We discussed this with the registered manager and asked about specific monitoring procedures for people following any concern that they may have sustained a head injury. The registered manager was unaware of the guidance for monitoring people following head injuries and confirmed no specific procedures were in place. Since the inspection a local authority safeguarding investigation into this incident has substantiated that the service had failed to manage the risk to the person as they had not sought medical attention promptly. Following our discussion with the registered manager they undertook to ensure that specific monitoring guidance for head injuries would be available for staff.

All of the examples above demonstrated that the provider and registered manager were not managing risks to people effectively. We were not assured by their responses to incidents and accidents or that they or staff were sufficiently competent to manage risks to people. People were not safe and were at risk of receiving unsafe, neglectful and inappropriate care.

Although we found the home was clean we observed some basic infection prevention measures that were not being followed by care staff. For example, whilst in the first floor communal area a person said they had an itchy back. A care staff member lifted the person's shirt and rubbed their back (over their vest). The care staff member then proceeded to butter some toast for another person without washing their hands. The sink in the first floor communal area was full of washing up waiting to be done and no other hand washing options were provided. This meant staff were not always washing their hands before making people drinks or snacks therefore exposing people to the risk of cross contamination and poor hygiene.

Medicines were not managed safely, this put people at risk of receiving medicines that may not be safe or effective. There was a medicines fridge in place and the temperature was being monitored daily and showed that these medicines were stored within the manufacturers' recommended temperatures. However, temperature monitoring charts showed the clinical room, where most medicines were stored, had exceeded the recommended maximum temperature of 25 degrees Celsius on 36 separate occasions between May 2017 and August 2017. This included occasions when it was recorded at 35 degrees Celsius. Additionally, there was nothing documented to evidence what action had been taken although the registered manager said that a cooling unit had been put in place on these occasions. The registered manager said they had not contacted a pharmacist for advice as to the continuing safety of medicines in use, although they did subsequently do this during our inspection.

Bottles of liquid medicines and eye drops had not been labelled by staff when opened which meant there was a risk that staff would not know when they had expired and were no longer safe to use. For example, a bottle of eye drops had a dispensing label of 19/07/2017. The bottle had been opened, but the instructions

on the label were to discard after 28 days. When we showed this to a member of staff they disposed of the bottle.

Medicines were not always stored securely. Medicines were stored in a treatment room which could be accessed via a coded lock, not by a key. Within the treatment room cupboards containing excess medicine stock were not locked and we saw keys were left in the cupboard doors. A box of 'just in case' medicines had been left out on top of the returns book. They had not been recorded in the returns book. The box included medicines which require specific secure storage. These were therefore readily accessible to any one entering the room. The registered manager agreed these were not being appropriately stored. The medicines fridge, located in the treatment room was also not locked and contained insulin.

There was a risk that people may not have received medicines that were necessary to their health. Medicine administration records (MARs) had not always been completed in full. We viewed the current MARs and saw five gaps where staff had not signed to indicate that people had taken their medicines as prescribed. Gaps had not been identified by subsequent staff or the registered manager. The registered manager subsequently asked a member of staff to check to see if the medicines had been administered. We also found that a medicine which had been signed as administered remained in the blister pack and had not been received by the person. The registered manager said they checked MARs weekly; however the errors had not been identified during their checks or followed up by other staff who were administering medicines on a daily basis.

Where hand written additions or changes to MARS had been made these were not being counter signed by a second staff member to confirm accuracy of the change to the prescription. This was contrary to best practice guidance. This meant should the first staff member have made an error this would not be identified placing the person at risk. Where people were receiving regular medicines such as Paracetamol which should be given at least four hours apart we found an adequate gap between doses had not always occurred.

There were some PRN (as required) medicine protocols in place that were person centred. For example, pain relief protocols detailed where people might experience pain, such as '(person's name) suffers with low back ache.' However, there was no information in place for the use of medicines which relieve agitation. For example, one person had been prescribed a medicine and the instructions on the MAR were 'when required to manage behaviour'. There was no guidance to inform staff of the type of behaviour or what other techniques should be used to support the person before resorting to medication. This meant the person may not receive the medicines when they required them or they may be given the medicine when other methods to support the person may be more suitable thereby avoiding the need for medicine. We also found that the reason why PRN medicines had been given were not always recorded which limited the effectiveness of the PRN administration form as a monitoring tool.

The failures to ensure the proper and safe management of medicines and to ensure risks relating to the safety and welfare of people using the service were assessed and managed were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain a level of independence by continuing to undertake some activities where there may be a risk. Individual risk assessments had been completed for two people who were able to make themselves hot drinks and a person was supported to continue to manage their own medicines however as stated earlier in this report this had not been managed effectively .

With the exception of one person, people told us staff managed their medicines. One person told us "The

staff give them to me." Another person said "The girls [care staff] give them to me."

The registered manager told us that they were able to obtain medicines promptly such as if a GP prescribed new medicines. The provider or a staff member was able to collect these from out of hours pharmacies, meaning there would not be a delay in the person commencing treatment. Systems were in place to ensure staff knew where to apply prescribed topical creams and electronic records showed these were being applied.

Staffing was not planned effectively. At the time of the inspection all peoples bedrooms were situated on the first floor of the service and we observed that access and use of ground floor communal rooms was limited. We were told by the registered manager that there were six people using the service that required at least two members of staff to assist them with their personal care and to assist them to mobilise or change their position. There were three care staff members on duty during the day and the nominated individual who was working as a senior 'floating' member of staff. A nominated individual is a person with legal responsibility for a service where this is a limited company. Whilst all people remained on one floor this staffing level met the basic personal care needs of people using the service. However, had people wanted to spend time on the ground floor in the communal areas this would have decreased the staff available to meet people's needs on the first floor as staff would have needed to remain with them on the ground floor.

We asked the registered manager how they planned their staffing level. The registered manager used a dependency tool to assess individual people's dependency and calculate the number of staffing hours required. The dependency tool did not take into account the more complex information about people's needs or the building layout. This meant the dependency tool was not an effective way of calculating the number of staff required for the service to meet people's needs in a person centred way.

We explained to the registered manager that we were not assured that the staffing levels were meeting people's individual needs. The registered manager agreed to review the staffing levels taking into account the layout of the building. Following the inspection the registered manager sent us further information relating to the dependency tool. We were still not assured as the dependency assessments for some people were incorrect and stated at a lower level of dependency than identified within their care plans. Further to this the registered manager had responded to state that ancillary staff were also able to assist on the ground floor of the home. This response did not assure us as staffing should be planned in a way that is not reliant on ancillary staff to meet people's needs. Ancillary staff that were listed included the provider (maintenance), hairdressers, cooks and the cleaner who were not suitably trained or skilled to deliver care. In determining the number of staff and range of skills required to meet people's needs, the registered manager should consider the different levels of staff skills and competence required to meet those needs. The registered manager had failed to do this effectively. The information provided by the registered manager did not assure us that they fully understood people's needs and dependency, and planned staffing to meet those needs

The level of staffing made it difficult for staff to spend quality time with people or provide them with person centred activities. We observed that staff spent most of their time being task orientated to attend to people's basic care needs. The levels of staffing meant that there were also occasions when people who were not independently mobile were left alone in the kitchenette area without access to a call bell and were reliant on calling out to staff. We observed people calling out from the kitchenette area; however, staff were unable to hear them due to the shape and layout of the building. The kitchenette area was the only communal area on the first floor. We also observed occasions when people with higher support needs were not receiving the care and support they required; we observed some people were ignored by care staff when they called out from their bedrooms. Some of these people were very vulnerable as they had profound dementia and were

not able to use their call bell or tell anyone how the lack of response affected their wellbeing.

People and staff gave variable response when asked about staffing. We asked one person if staff had time to come in and chat with them and they told us this did not happen. Another person felt there were enough staff. One person told us staff responded fairly quickly when they used their call bell. Staff said there were enough staff on duty to meet people's needs. One member of staff said "I think there is enough staff, we're fine. If we didn't have enough [registered manger's name] would check where we need to improve." Another member of staff said "I don't think we need any more staff, sometimes there are quiet periods when we can interact with people."

The failure to ensure staffing was planned effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy and procedure regarding the safeguarding of people and guidance was available in the office area for staff to follow. Staff told us that they would report any issues of concern to the registered manager and felt confident their concerns would be taken seriously. One staff member said "I know where to find phone numbers and the websites for the CQC if I need to report anything but [registered manager's name] would sort it out before it ever got to that." Another care staff member said "I would tell [registered manager's name] and we have access to the phone numbers if we needed to let safeguarding know." The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. However we were not assured that staff or the registered manager were able to recognise that omissions of care can amount to neglect and that this should be reported as such. As detailed earlier in this section of the report staff had on occasion failed to provide people with care that was necessary to maintain their health and wellbeing.

Providers are required by law to notify CQC of significant events that occur in registered services. This allows CQC to monitor occurrences and help keep people safe. We identified safeguarding incidents, which had not been reported to us. Discussions with the registered manager showed they had taken action to report these to the local safeguarding team and ensure the safety of the person concerned. The registered manager understood they needed to report these incidents to us and could not explain why they had not done so. They stated they would ensure this occurred in future. We had received notification of other occurrences as required.

People who were able to speak with us told us they felt safe at Bluewater Nursing Home. When asked if they felt safe one person told us, "Definitely, there's always someone around. They help steady me when I stand. I've had no falls." Another person said, "They are very good staff." A visitor told us how staff kept people safe. They said "They [care staff] made me sign in, walked me to the room and double checked with [the person] that she knows me."

There was a robust selection procedure for staff. Staff recruitment files showed that the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

Emergency procedures were in place. The fire risk assessment was out of date and the service had been issued with fire safety breach notice following an inspection by the fire brigade in April 2016. On the first day of the inspection the provider was unable to evidence that action to meet the concerns raised by the fire service had been met although they stated this had occurred. They subsequently arranged for a fire safety

company to review the assessment which showed required action had been taken. Staff knew what action to take if the fire alarm sounded, and told us they received fire safety training. People had individualised evacuation plans in case of an emergency, which identified the support and equipment they needed to leave the building in an emergency situation. Records showed fire detection and firefighting equipment was regularly checked. Staff had been trained to administer first aid.

Requires Improvement

Is the service effective?

Our findings

Consent to care and treatment was not always managed in line with legislation and guidance.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Assessments and decisions were not always recorded in accordance with the MCA Code of Practice. Where people lacked the ability to make decisions, such as those relating to care, best interest meetings or discussions had not been recorded.

Some people did not have the mental capacity to make certain decisions. These included decisions around the delivery of personal care, the use of bed rails, the use of alarms to alert staff they were moving about the home, and the administration of medicines. Although people's capacity to consent to aspects of their care had been assessed, this had not been undertaken on a decision specific basis. For example, one person had been assessed as lacking capacity to consent to the use of bed rails. Although there was best interest documentation in place which showed the person's relative had been consulted, there was nothing written to show that other less restrictive options had been considered or the reasons why they had been rejected. Another person had a movement sensor mat in place, but there was nothing documented to show the person's capacity to consent to this had been assessed or to show how staff had reached the decision to use it in the person's best interests.

In one person's care plan staff had documented that a relative had been granted Lasting Power of Attorney (LPA) for health and welfare matters and a copy was filed within the plan. Where a relative or other person has power of attorney for health and welfare matters this would only relate to decisions the person was unable to make. Therefore an assessment of the person's ability to make each decision should be undertaken. Where this showed the person was unable to make the decision in an informed way then the person with power of attorney should be approached to make the decision. However, the person's care plans stated 'Decisions made in [person's name] best interests when considering medication, personal care, nutrition and supervision'. These decisions should have been made by the person with the LPA and not by staff.

Staff understanding of the MCA was variable. Two members of care staff stated that best interest decisions were made by people's next of kin and made no mention of how capacity should be assessed prior to this. One member of staff was able to explain the MCA and best interest process with some prompting. Care staff lack of knowledge as to how to implement the MCA on a day to day basis meant we could not be assured that people's legal rights would be protected.

The failure to ensure that, where people lacked the capacity to give informed consent, action was taken to comply with the Mental Capacity Act when providing care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Mental Capacity Act 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we checked whether the service was working within the principles of the MCA, and whether DoLS applications had been made appropriately. We found the provider was following the necessary requirements in relation to DoLS and appropriate, DoLS applications had been made where needed. We asked the registered manager about conditions on DoLS and were told there were no added conditions. However, when we returned on 4 December 2017 we identified that there had been a condition on a person's DoLS which was not being met. The registered manager said the condition was not appropriate for the person however they had not acted to inform the DoLS team at the local authority of the need to review the condition. The provider's records did not evidence that they had been in contact with the DoLS team.

Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The expectation of the provider was that each staff member received a supervision every six to eight weeks. We looked at the supervision matrix with the registered manager who confirmed that supervisions had not been taking place at this frequency due to staff changes. We looked at the supervision records of four members of staff; we found that for some staff, supervisions were not meaningful as they had been undertaken in a way that did not provide them with valuable feedback about their performance or development. Annual appraisals had been undertaken and were also variable in quality. We were not assured that the provider had ensured that staff performance and progress was monitored effectively.

The failure to ensure that staff received appropriate ongoing or periodic supervision was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported through the provider's mandatory training programme which included safeguarding, fire safety, first aid, infection control and moving and handling training. The registered manager showed us the staff training record matrix that was in place but was unable to state how accurate or up to date the system was as there was conflicting information between the matrix and the records for online training. In some instances the matrix evidenced training had been completed, however the online training records did not and vice versa. The registered manager confirmed that there was no easy way to check that relevant training had been undertaken due to the complexities of managing and extracting information from the current training record database. Staff told us they had completed a variety of training courses relevant to their role, however they were unsure when they last attended training. New staff had received the provider's induction and had started to undertake the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. Staff we spoke with said they felt well supported and could ask the registered manager for support.

People's general health was monitored. A person told us, "They've asked if I want to [see a doctor] but I've said I'm alright." The registered manager was aware of how to contact health professionals, including home visiting opticians and dentists should these be required for people not able to go out to clinics or surgeries. Records showed that people had been reviewed by the GP, the community mental health team and the district nurse. One person was living with diabetes and records showed staff were monitoring the person's blood sugar levels as directed in their care plan. Should people require to be transferred to other care settings, such as hospital, the registered manager stated that a senior member of the management team or a member of staff would always accompany the person if a relative was unable to do so. They explained this was to ensure essential information was provided to hospital staff and support the person in the unfamiliar environment. On the first day of the inspection two members of the management team were seen taking a person for a routine outpatient appointment. The home had a wheelchair accessible vehicle that they used at no cost to people for transport to and from hospital when needed. We spoke with a visiting healthcare

professional who was complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

People we were able to speak with said they received the personal care they required. One person told us, "I have a shower every day." Care staff described how they supported people, which reflected the information in their care plans. Staff recorded the personal care they provided to people, including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal care needs. We did however observe that not all people received access to personal care when required; there is more detail about this in the responsive section of this report.

People were supported to have enough to eat and drink. People's care plans detailed their preferred food and drink choices and any special requirements were documented. For example, in one person's plan it was documented that when drinking in bed they preferred to drink out of a light cup with a straw. Another person needed full support with their nutritional needs due to poor eyesight. The plan detailed the support the person needed and included the information that they could manage independently when eating finger foods.

Some people were having their food and fluid intake monitored. We looked at the food and fluid charts for these people and saw that they had been completed in full. However, we noted occasions when care staff had selected the incorrect amount of fluid on the electronic recording system. The failure to ensure these records were completed accurately exposed people to the risks of de-hydration. We discussed this with the registered manager who agreed the amounts were incorrect and stated they would remind staff of the need for accuracy. All of the charts we looked at showed that generally, people's targets had been met.

People told us they were happy with the food provided by the service, which they felt was very good. One person said "It's very good. The chef comes round about an hour before the meal to see what you would like. If you want something different they will do that." Another person told us about the food which they described as "Excellent, the chef has just been to visit about lunch. I'm having poached fish. She's a good chef. I had scrambled egg this morning." The cook was aware of people's preferences and dietary needs. They told us that where people had dietary needs linked to medical conditions, such as diabetes, they were aware and able to provide a suitable meal. Drinks and a range of snacks were also offered to people throughout the day. One person told us "There's always a cup of tea being offered but if I'm hungry I can always ask for something like beans on toast." Staff told us they could provide people with food at any time this was requested or required.

Staff were aware of people's dietary needs and preferences, meals were appropriately spaced and flexible to meet people's needs. People were able to choose where they ate their meals. Some were happy to eat in the dining room, others in their bedrooms. Mealtimes were an unrushed social event and staff engaged with people in a supportive, patient and friendly manner.

The home provided an environment suited to the needs of people living there, however during the inspection the environment was not being used to its full potential. At the time of this inspection everyone was accommodated on the first floor of the home with the additional second and third floors not in use. The main communal rooms were located on the ground floor. These included a bright dining room, lounge area with additional beach style sensory room, conservatory and a cinema room. With the exception of a few people who watched a film in the cinema room during the afternoons, and lunch time when people used the dining room, people spent most of their time on the first floor in a small communal area; this area could not accommodate more than six people seated at a time. This did not have adequate comfortable seating for all people and was in an internal area, with bedrooms located off this area and with no natural light.

The provider had added décor to support people living with sensory impairment or dementia to safely navigate around the home with hand rails of contrasting colours to the walls provided. The home was decorated in an individual style to reflect the history of the building and walls were covered with numerous items which may stimulate memories for people. However, for some people the amount of decoration may have proved overwhelming and confusing. For example, there was a seated mannequin, bumper cars with mannequins and very large metal giraffe ornaments located on balconies visible from bedroom windows. At least three clocks were noted to be on the wrong time, including those in the first floor communal area where people spent most of their time and in the dining room. This could be disorientating for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Staff did not always treat people with dignity and respect. Although most interactions we observed were positive we noted instances when this was not the case. On one occasion when we were in the first floor communal area we heard two staff talking about a person, using the person's name and describing some personal care that had just been provided for the person. Other people were in this area and would have heard the conversation which should have been conducted away from people. On another occasion we overheard staff talking about a person being on the commode. There were four other people present who would have also been able to hear this. We heard a person who called out being ignored. We asked staff to attend to the person and were told they always called out. The registered manager went in to assist but it was clear that the person was not always attended to when they called out. At another time we heard another person call out and again staff did not respond although they were in the area. This situation continued on the second day of the inspection. Throughout the day one person was often shouting "Help". Staff sometimes went into provide reassurances, offer a drink, sometimes they just said in passing comments such as "what's wrong", or "are you alright". We observed that when people were more 'difficult' to care for the staff ignored their needs. At one point both the television was on and some music was playing in this area. This would prove distracting to anyone trying to focus on either source of entertainment.

Staff described the practical steps they took to preserve people's dignity when providing personal care. On most but not all occasions we saw that before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. Care staff explained how they always closed curtains, kept people covered as much as possible and told people what they were about to do. This would help ensure people's privacy and dignity during personal care. One bedroom was being used by two people. Privacy screens were available meaning personal care could be provided in private. One person said "One male [staff member] has just started but he helps with the food. Otherwise it's female." At the time of the inspection all care staff were female meaning people did not have a choice about the gender of care staff providing personal care. However, this did not appear to be of concern to people.

People we were able to speak with and visitors spoke warmly about the staff. One person said that staff were "very good." Another person said "They're [staff] all very nice." A third person said of the staff "You couldn't wish for better people." These comments were echoed by other people and visitors we spoke with, including a visiting health professional who told us, "They [care staff] seem to be caring and don't change often so they have got to know the residents." We observed a care staff member talking tenderly to a person, "[Person's name] are you going to have a bit more drink for me."

The atmosphere was mostly relaxed and friendly. People appeared relaxed around staff. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Before leaving a person seated in the first floor communal area care staff ensured the person was all right. We saw staff took time to ensure a person was sat comfortably on the sofa in a communal area. Staff checked with a person if they were warm enough and suggested a cardigan which they fetched for the person. We heard good-natured banter between people and staff showing they knew people well. One person said "You can have a joke with them [staff]." The home did not use agency

staff with existing staff or members of the management team providing additional support when this was required. This meant people were cared for by staff who had the opportunity to get to know them and their needs.

The registered manager told us how a member of the management team had supported a person when they were informed a person who was at the local hospital was receiving end of life care. The provider enabled the person's relative, who could not attend due to distance from the hospital, to speak with the person in their last minutes via speaker phone. Although the person couldn't speak they were able to hear and gain comfort from hearing their relative's voice.

People were usually offered choices and their decisions were respected. People confirmed this when talking about meal and other choices they were offered. One person said "I can go down [to the dining room] if I want, but I choose to stay up here [for meals]." Another person said, "They usually come and ask if I want to get up." They added "Usually I say 'can I get into bed now' and they say 'yes'." We heard a staff member ask a person if they wanted a cup of tea. At another time we heard a person asking a staff member for a cup of tea which was promptly provided. This showed people felt comfortable telling staff what they wanted. Some people living at the home had a diagnosis of dementia. This can affect their ability to make choices. The chef told us they were soon to have pictures of various meals to help people make a more informed choice about what they would like to eat.

Care files contained information about people's lives, preferences and what was important to them. For example, in one plan there was guidance for staff on how to prevent the person becoming socially isolated. The activities the person enjoyed and the entertainment they liked had all been documented. Staff were aware of this information. For example, we heard one person talking with a staff member. It was evident from the conversation that the staff member knew about the person's relatives as they mentioned the names of several family members. People were supported to maintain family and other important relationships. Visitors told us they were made welcome and felt able to visit at any time. A person told us how staff helped them remain in contact with distant family members. They said "I have two sons, one in America and one in Australia. They phone and the staff bring me the phone to speak to them." One person had been enabled to bring their much loved dog with them when they moved to the home. Staff were supporting the person to ensure the dog received all the care it required. Another person had brought their cadged budgerigar with them. Care staff told us the person's family undertook most of the care but they always checked it had food and water.

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over and adapted plates were provided where necessary. We saw a person was struggling to eat with a fork. Staff noted this and offered them a spoon to make independent eating easier. A range of drinking cups was available to suit the various needs and preferences of people.

The registered manager explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans. Where people had spiritual needs these were known and met. Care plans detailed any spiritual beliefs or needs a person may have and how they liked these to be met. Christian religious leaders attended the home fortnightly and provided a service for people who wished to attend. The registered manager was aware of how to access religious leaders of various faiths if required.

Requires Improvement

Is the service responsive?

Our findings

Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. Care plans were then developed, which contained information about areas such as people's life history, preferences, personal care, continence and nutrition. These detailed what people could do for themselves and how they needed to be helped. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels. Copies of care plans were accessible to care staff should they need to refer to these. Reviews of care were conducted regularly by the registered manager.

We found however that care plans did not consistently contain all of the information required to enable staff to support people appropriately.

One person was nearing the end of their life and records showed this had been discussed with the GP and with the person's family. However, the end of life plan was minimal and did not include details about the person's choices about their end of life care. The care plan stated that the outcome was for the person 'to have a comfortable and pain free end of life', but the plan did not inform staff how to ensure this happened. The plan stated that the home and family were preparing for the person's end of life needs; however these needs had not been identified. The records showed the person's fluid intake had deteriorated, but there was no plan in place for how staff should provide mouth care. Although the person's pain management would be delivered by the district nursing team, there was nothing documented to guide staff on how to recognise if the person was in pain. The person's spiritual needs had not been documented. Although there was a plan for the person's emotional needs, this was limited to guiding staff to 'pop in and out of the room throughout the day and say hello' and 'ask if he wants or needs anything'. There was one entry that was person centred; 'likes to stroke the face or hold your hand; works really well for [person's name] – he enjoys it', but this was the only example within the person's end of life plan.

Information about people's emotional and behavioural responses is significant in a service for people living with dementia to aid staff in understanding how people communicate their needs, and how to respond appropriately. This information is of particular relevance when new staff are employed to aid them in providing people with a consistent and appropriate response.

In one person's care plan it had been documented that they were 'an angry and frustrated person' and that they may strongly ask staff to leave their space. The person had been prescribed medicines to relieve their agitation. It had been documented that the medicine should be administered if the person did not respond to distraction techniques, but these techniques were not documented. There was a risk that staff would resort to using medicine without the information on how to distract the person.

In another person's care plan it was documented that they often called out or screamed. However, the guidance for staff was to 'go and see if they can find out what's troubling her'. There was no detail of any identified triggers that might cause the person to call out or specific recording to help identify triggers. We heard the person calling out several times during the inspection. Staff did not always go and see what the

person wanted.

Following the inspection the registered manager sent us information that stated that for one person who regularly called out 'help' their relatives had told the registered manager that the person had always called out 'help', and this was a symptom of the person's dementia. This was in response to us raising concern that the person was not receiving an adequate response from staff. However, family members may be unaware of how people with behaviours that challenge, such as repeatedly calling out should be cared for in respect of this behaviour. To state that a person who repeatedly called out 'help' is a symptom of their dementia shows a lack of understanding about how to support people with behaviours that challenge. The person could be calling 'help' for a number of reasons which staff should explore on each occasion and not just walk past them. The person could have been scared, uncomfortable, require repositioning or they could have been thirsty, in pain, too hot or too cold. The information provided by the registered manager did not assure us that they fully understood people's needs and dependency.

We also found some conflicting information within care plans. For example, in one person's care plan there was a section relating to communication. This detailed that the person's speech was slightly slurred due to a specific neurological condition and additional time and patience was needed to understand them. In another section of the care plan it stated the person could communicate fully and did not need any additional support.

In all of the examples above there was a risk of people not receiving person centred care, because staff did not have the information available in relation to all of the people they were caring for.

We also saw occasions when people's needs were not responded to by care staff. A person was asking for the toilet. A care staff member told them that another named care staff member would take them however this did not happen. We were concerned that care was not always provided in a way which met people's individual needs. We noted another person's finger nails were long and looked dirty underneath. We saw a care staff member take a person's hand as they were walking around with us. The care staff member asked the person where they wanted to go, and appeared to be leading them a little too fast for their abilities. The person replied "Anywhere as long as you don't pull me". At lunch time we saw a person sat in a chair in their bedroom, the clothing protector from lunch hanging off them and pudding was on the arm of their chair. The person's table was not in a position from which they could have easily used it to eat from.

People did not always receive consistent responses from care staff. We observed care staff using a variety of different responses to reassure / respond when one person was repeatedly asking for a relative's phone number or another person who was asking to go home. Some care staff were distracting people by talking about where they lived and what this was like. Whilst we heard another staff member just say, "You can go home later yeah?" We discussed this with the registered manager who agreed to consider how staff should best respond to these peoples requests.

Peoples' wellbeing was not promoted due to a lack of activities to meet their social and emotional needs. In the entrance hall the activities for the day were listed as hairdressing in the morning and cake decorating in the afternoon. On the morning of the first day of the inspection the hairdresser was visiting and several people were taken to the ground floor to have their hair done. In the afternoon we saw several people went to watch a film in the ground floor cinema room. The cake decorating activity did not occur. We asked a care staff member about the cake decorating activity. They told us "We have a choice of cake decorating or a film. We go and ask people and then go with the most numbers." For people who did not go to watch the film we saw a care staff member organised some colouring with people sitting in a small communal area on the first floor. For people who remained in the first floor communal area we saw the television was on throughout

most of the day although nobody appeared to be watching this. We also noted the television was on in the dining room throughout lunch although, again, nobody appeared to be watching this. On the second day of the inspection the provider verbally asked people about activities in the late morning to which people declined. Most people sitting in the first floor communal area may have responded better if activities had been placed onto the table and staff sat to join in. In the afternoon five people watched a film in the ground floor cinema room. However, they were not offered a choice of films and we heard one person say they would have gone if it had been a Frank Sinatra film. As soon as the film finished people returned upstairs meaning the communal lounge on the ground floor was not used at any time during either day of the inspection.

Most people we spoke with felt the activities they received did not provide adequate mental and physical stimulation. One person told us there were "sometimes" activities although they said there were "not a lot". They added that they had a "TV which I watch." Another person told us they got "a bit bored", and tended to stay in their room. When asked about activities a third person said there was "sometimes a singalong."

The failure to ensure people received person centred care and support is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found other sections of care plans contained more individual information and guidance for care staff. Communication plans we looked at were very detailed. For example, in one plan it had been written that staff should make sure the person could see their faces when speaking to them as it tended to help the person understand better. When people had medical needs the care plans contained details of any medical conditions. We saw that one person was diabetic and the plan detailed how staff should support the person. The signs and symptoms of low blood sugar and associated action required by staff were in place. People's preferences in relation to how they liked to take their medicines had been documented. When staff needed to use equipment to move people safely, the details of hoists and slings to be used was documented. All care plans had been regularly reviewed and where possible people and their relatives had been involved in these.

People who were able to speak with us and relatives were happy with the way their personal and other care needs were met and told us that the care staff knew their preferences and respected their wishes. One person said, "The staff help me when I need help." A visiting social care practitioner told us the registered manager had undertaken a comprehensive assessment of the person's needs following an emergency admission to the home.

We asked people if they knew how to make a complaint. They told us they would talk to the staff or the registered manager. One person said, "I'd speak to [name of registered manager] if the girls couldn't sort it." However one person told us that although they were generally happy, that concerns or complaints were not always addressed. The person said "I'm sick of saying things and nothing gets done, so I think, oh blow it." We asked the registered manager for the complaints made since the last inspection. The registered manager stated that there had been no formal complaints made. However, a relative of a person who had received a service at the home shortly before this inspection told us they had raised a complaint with the registered manager. The registered manager told us that when informal complaints were made these were often quickly resolved with people and relatives. We asked to see the records of informal complaints and were told these were not recorded. Complaints assist providers in identifying trends and common concerns and can assist them in learning how to improve the service based on what people tell them. The lack of recording informal complaints meant that the provider could not be assured that they were aware of all of the issues affecting people using the service and were able to act on these complaints to improve the service. The registered manger took action to record informal complaints about the service.

Inadequate

Is the service well-led?

Our findings

There was a clear management structure to the service; the provider of the service was often on-site and took a lead role in managing the maintenance of the home, providing support to the registered manager who was a family member and also meeting with external stakeholders. The nominated individual was married to the provider of the service and also the mother of the registered manager. A nominated individual is a person with legal responsibility for a service where this is a limited company. The nominated individual also worked within the home as a member of care staff and assisted the registered manager in overseeing staff. At the time of the inspection we were told that a deputy manager was being recruited but was not yet in post. The provider had also contracted a consultant to work with the home to ensure quality assurance procedures were appropriate. The consultant was planning to undertake a formal assessment of the home but this had been delayed.

During the inspection it was clear that on a number of occasions the registered manager was unaware of all of the responsibilities associated with their role; this also impacted on the ability of staff to know what good standards entailed as they were following the lead of the registered manager. There were no documented provider led quality assurance procedures that ensured that there was adequate oversight of the registered manager and the quality and safety of service provision. The registered manager skill set was in need of development and they were not up to date with current good practice this had not been addressed by the provider.

Our findings from previous inspections have shown a history of non-compliance with the regulations; all comprehensive inspections have resulted in Inadequate or Requires Improvement ratings. Breaches of regulations have covered a range of areas, and when improvements have been made, these have not been sustained. Since our last comprehensive inspection in October 2016 the service had managed to become compliant with regulations for a short time; we found them compliant at a focused inspection in July 2017. However at this inspection we found the service had again become non- compliant and standards had further deteriorated. At this inspection we identified five breaches of regulations, three of which were continuing breaches from our last comprehensive inspection in October 2016.

Whilst in the short term the provider had been able to improve the service to meet standards they had not been able to sustain this improvement in the long term. As at other inspections, a number of the shortfalls related to matters which had been brought to the provider's attention on previous occasions. These related to key aspects of the service, such as safe care and treatment, person centred care, records and good governance.

The registered manager or other senior staff undertook audits of the service. These included audits of infection control, care plans and the environment. Internal medicine audits had been carried out. When these had identified issues we saw action had been taken. For example, staff medicine competencies had been checked and directions for obtaining medicines out of hours had been made available. However, the internal medicine audits had not identified the issues we found with the management of medicines such as failure to take action when medicines were stored at higher temperatures, lack of PRN guidance for

medicines to support people with anxiety and ensure safe systems were in place for the disposal of liquid medicines once these had been opened beyond a safe to use date. The quality assurance systems and processes undertaken by the registered manager did not ensure that they were able to assess, monitor quality provision and mitigate the risks and relating to the health, safety and welfare of people and others who may be at risk in the service. The quality assurance systems used were ineffective in assessing where the service required improvement and implementing and sustaining improvement effectively within a reasonable timescale. There were widespread and systemic failings identified during the inspection which are detailed throughout this report.

The registered manager completed a monthly report to the provider detailing actions that they had taken and actions required. For example, the report documented if people had lost weight, had falls or accidents and any infection control concerns. The registered managers' report also contained information of the home's dependency level, of new admissions and discharges, any safeguarding issues, staff training, supervisions, and any other matters arising. The registered manager had identified areas of the home which could be improved such as improving the courtyard garden and providing furniture which reflected the history of the building. The provider had made lots of improvements in relation to the décor of the building and purchasing items such as art deco furniture however this type of improvement did not make the impact that was required to meet the fundamental standards that relate to regulations.

We were told the registered manager and nominated individual also frequently visited the home at times outside of planned visits enabling them to monitor the quality of service provided but records of this were not kept.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. Risk assessments were not always up to date, placing people at risk of not having all their needs met in a consistent and safe way. There was also a failure to identify recording errors and omissions in the care records and to analyse concerns. When reviewing care related records we found that staff were not always accurately recording the volumes of fluids people were receiving; this had not been identified by the registered manager. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment. Some other records such as those relating to staff training and records of servicing of equipment or services were not readily available when we requested these

Records were not always recorded at the time which may affect their validity. On the second day of the inspection we viewed the medicines fridge temperature chart at 10.10am. This had been completed up until the end of November 2017. No entries had been made for December 2017. Those that were recorded were all in range as was the current temperature on the fridge. At 2.30pm we again viewed this record and saw entries had been made on this chart for the dates of the 1 until 4 December 2017. This was immediately brought to the attention of the registered manager who could not provide an explanation. We discussed this again at the end of the inspection. The provider advised that they had done this. They said they had memorised the temperatures over the weekend and completed the record sheet on the day of the inspection. They added that the temperatures only ever vary by one degree. Records should be made contemporaneously to ensure accuracy and to ensure that prompt action can be taken to address any concerns when necessary.

Following the first day of the inspection we provided verbal and written feedback to the provider and registered manager. When we returned for the second day of inspection we found that they had taken some action to address the issues we raised however other issues remained. These included concerns around the

management of medicines and completion of records relating to medicines management and ensuring risks to people from falls or the actions of other people living with dementia were appropriately managed.

Following the inspection we asked the provider for an action plan in relation to the risks to people and concerns we identified during the inspection. We also asked them to review their admission strategy for the same reasons. The registered manager submitted an action plan which did not cover all areas of concern or assure us that concerns would be addressed in a timely way. The strategy for admissions was also inappropriate considering the concerns we had raised in the report about the service.

The inspection history of the service has demonstrated that the provider is unable to sustain and improve the service to the standards required. Given that the service had never been more than just over one third occupied we are concerned that should occupancy increase standards may be further compromised. The actions taken by the provider in response to this and previous inspections have not assured us that they are able to make the improvements required.

The failure to provide good governance to ensure the safety and quality of service provision is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some external health and social care professionals felt the home was well managed others did not. One told us how the registered manager had supported them in making an emergency placement out of hours at the service. Another told us the registered manager contacted them appropriately to discuss any concerns or issues with people and followed their advice and guidance. Some external professionals said they would recommend the home and would be happy for a member of their own family to be accommodated there. Other external professionals told us they had a difficult working relationship with the provider who they said did not engage with them positively.

People we were able to speak with were positive about their experience of living at Bluewater Nursing Home. One person said, "This place is really nice." Other comments included "I think its fine here" and "Very good, lovely." People and visitors were aware of who the registered manager and provider were and all said they felt able to talk to them if required. For example, when asked if they knew who was in charge one person said "[Manager's name] she's in an office downstairs." Whilst another person told us they knew who was in charge. People also felt the service was well run. Their comments included "I don't know that there is anything I would change." "Everything is fine." And "Everything is run well." One person told us "There were some teething problems initially but all sorted now."

The registered manager told us they also ensured the quality of the service provided by talking to people, relatives and staff. More formal quality assurance systems were also in place, including seeking the views of people about the service they received. Surveys had been sent to people, visitors and external professionals in January 2017, there had not been another formal survey since our last inspection of the service The results of the surveys had been analysed and information from this was available to people and visitors in the entrance area of the home. The home continued to seek the views of people, visitors or others and there was a suggestions and ideas box located in the entrance area. Between the two days of the inspection the provider had undertaken a survey of people and visitors views about the service. We saw that these were all positive about the service people were receiving. Despite the positive feedback we received from people who were able to speak with us we remained concerned that not all people received care that met their needs. This was because we observed staff ignoring people living with dementia who were distressed and unable to communicate their needs. There is more information about this in the responsive section of this report.

The registered manager described their goal for the home as being to "create a community where people could be happy" and also to "promote independence". The registered manager also told us the company motto, which was embroidered on of the staff uniforms was "Proud to Care". Staff also described their goal as being to make people as happy as possible. All staff members said they would be happy for a member of their own family to receive care at the home.

The registered manager said they held meetings with people although these had not been as frequent as they would like them to be. There had not been any meetings since December 2016 when the previous manager had been in post. The management team also sought feedback from the staff team. Staff meetings were conducted. We saw the minutes from the meeting held in August 2017. These provided an opportunity for the management team to reinforce some aspects of the service to staff but also provided an opportunity for staff to raise suggestions or issues should they wish to do so. A staff member told us they felt able to approach any of the management team and felt that they would be listened to.

One staff member said of the management team, "They are lovely, they really care about the residents and staff. They ask me how I am and if I have any problems would do whatever they could to sort them out." Another staff member told us the management team were always "available out of hours" should there be any problems or support required. Staff said they felt well supported by the registered manager. One member of staff said "[Registered manager's name] is very approachable; she is always working to improve the home, is helpful and does her part." Another member of staff said "[Registered manager's name] always works with us and is always reflecting on what we do." Staff also said they enjoyed working at the home. One staff member said "I love working here. I get on with all of the team even though we are all different ages."

Policies and procedures were supplied via an external company and had been adapted to the home and service provided. We were told policies were reviewed yearly or when changes were required and updates were received from the external company when legislation or best practice guidance changed. We saw these were available for staff in the office and ensured that staff had access to appropriate and up to date information about how the service should be run.

Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The registered manager understood their responsibilities in respect of this and was in the process of writing to a relative following an incident at the service. Family members were also kept informed verbally of minor incidents and changes in their relative's health.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in July 2017, was appropriately displayed at the home and on the provider's website.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to ensure that care plans stated people's preferences and ensured their individual needs would be met. Regulation 9 (3)(b)

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure that where people lacked the capacity to give informed consent action was taken to comply with the Mental Capacity Act when providing care and treatment. Regulation 11 (1)(3)(4)

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure the proper and safe management of medicines and that risks relating to the health and safety of people using the service were assessed and action taken to mitigate identified risks to ensure the safety of people. Regulation 12 (1)(2)(a)(g)

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The registered person has failed to have systems or processes to assess and monitor the service and effectively ensure compliance, has failed to assess, monitor and mitigate the risks relating to health, safety and welfare of people and others and has failed to maintain records relating to people and management of the service. Regulation 17 (1)(2)(a)(b)(c)(d)

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person has failed to ensure that staff receive appropriate ongoing or periodic supervision in their role to make sure their competency is maintained. Regulation 18(2)(a) Staffing had not been planned effectively. There were not enough skilled and competent staff to meet peoples needs. Regulation 18(1)

The enforcement action we took:

We have added conditions to the provider's registration.