Blossom Care Home Limited

Blossom Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Blossom Care Home took place on 22 and 24 November 2016 and was unannounced. The location had been previously inspected during February 2016 and was found to be 'Inadequate' at that time and the service was placed into special measures. During this inspection, we checked to see whether improvements had been made. We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care, safe care and treatment, governance and staffing. We also found breaches in relation to consent, premises and equipment and meeting nutritional and hydration needs. In addition, we found a breach of the Care Quality Commission (Registration) Regulations 2009 because the registered provider had failed to notify the Care Quality Commission of specific incidents.

Blossom Care Home is a residential home, registered to provide care for up to a maximum of 20 people. There were 12 people living at the home at the time of our inspection.

The service had a registered manager in post at the time of our inspection. However, the registered manager had been absent from work due to maternity leave since March 2016. We had been advised by the registered provider that Blossom Care Home would, 'Run as normal in the absence of the registered manager.' The registered provider told us this was because they would be present and were familiar with the home, residents and staff and they would continue to manage the home alongside a senior care assistant.

The registered provider was not present at the home on a day to day basis and had engaged an agent to be involved in the day to day running of the home. The agent had appointed an interim manager, who had been in post for two weeks prior to our inspection.

The staff we spoke with understood the signs to look for which may indicate potential abuse and staff were clear about who they would report concerns to. However, the registered provider had failed to notify the Care Quality Commission about some allegations of financial abuse in line with legislation.

We found multiple risks to people had not been assessed and care plans were not sufficient to ensure everyone's needs could be met safely. Some care records did not contain information which would enable staff to safely assist people to move. A person who was at risk of choking did not have an associated risk assessment in order to provide staff with the information they would require to safely assist the person.

The premises were not safe and an enforcement notice had been issued by the West Yorkshire Fire and Rescue Authority. Some work which was required, in order to meet the requirements of the enforcement notice, had not yet begun. Some people did not have personal emergency evacuation plans in place which meant they could be at risk of harm in the case of an emergency evacuation.

Staff had been safely recruited and we found staffing levels had improved since the last inspection.

Medicines were managed and administered in a safe way.

There was a lack of staff support, supervision and training. We could not find evidence, and the interim manager was unable to confirm, what staff training had taken place. There was no training matrix in place and some staff told us they had undertaken training but had not been issued with certificates. Evidence of staff supervision was lacking and staff told us they had not received regular one to one supervision in order to monitor their performance and development needs.

The registered provider was not acting in accordance with the Mental Capacity Act 2005 (MCA). Some people had decisions made on their behalf without the principles of the MCA being followed.

The cook did not have the necessary skills and knowledge to ensure people's nutritional needs were met. This meant meals were not fortified when necessary and a person's diabetes was not managed effectively.

Some recent improvements to the environment were evident such as new flooring and freshly painted walls in some areas. Some people's bedrooms were not personalised.

People received support to access additional healthcare such as GPs and district nurses.

We observed staff to be kind and caring. Everyone we spoke with told us staff were caring. We observed people appeared comfortable and relaxed in the company of staff.

Two people did not have care plans in place and some other people's care plans were lacking in information. Care plans were not regularly reviewed and people were not involved in developing or reviewing their care plans.

One person told us they were bored and we found there was a lack of meaningful activities.

People were able to make their own choices, such as what to eat, what to wear, where to sit and what time to rise.

A new interim manager had been appointed and had been in post for two weeks. However, we found a continued history of inadequate management at Blossom Care Home. There was a lack of management oversight. For example, regular safety checks had not been completed, audits had not been completed, there was a lack of staff support, people's views were not sought and acted upon, the premises were unsafe, risks were not assessed, records were not kept and emergency plans were not in place.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

People told us they felt safe.

Risks to people were not always assessed.

The premises were not safe and regular safety checks had not been carried out.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive regular training and support.

The registered provider was not acting in accordance with the principles of the Mental Capacity Act 2005.

People did not receive appropriate support in relation to their nutritional needs.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

Staff understood how to protect people's privacy and dignity.

Positive interactions were observed between staff and people who lived at the home.

Is the service responsive?

Inadequate

The service was not responsive.

People told us they were bored and there was a lack of meaningful activities.

Care plans lacked detail and people had not been involved in reviewing their care plans.

We observed people were offered choices throughout the day.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems and processes in place for auditing the quality of service provision.

There was a lack of management oversight at the service.

Previous breaches of regulations and areas identified as requiring improvement had not been addressed.

Blossom Care 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.

The inspection of Blossom Care Home took place on 22 and 24 November 2016 and was unannounced. The inspection team consisted of two adult social care inspectors on the first day and an adult social care inspector on the second day.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority and the clinical commissioning group as well as information we received through statutory notifications.

The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us to understand the experiences of people who lived at the home, including speaking with people, making observations and inspecting records. We communicated with six people who lived at the home, a relative of a person who lived at the home, the interim manager, two care staff, a cook and two visiting professionals.

We inspected seven people's care records and three staff files, as well as records relating to the management of the service and the maintenance of the home. We looked around the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We asked people whether they felt safe living at Blossom Care. A person we spoke with said, "I feel safe living here. Things are alright. If I need anything I press the buzzer. Staff attend quickly."

A family member told us, "[Name] feels safe living here. I've never seen anything that's concerned me."

A visiting professional also told us, "I've never seen anything that's concerned me."

A person who was assisted by staff to transfer by using a hoist told us, "There are always two people to help me. It's a manual hoist. I feel safe in there."

The interim manager and the staff we spoke with were aware of signs to look for in people which may indicate they were at risk of abuse or harm. Staff were clear of the actions they would take and they told us they would escalate any concerns if they felt they were not acted upon appropriately. This helped to ensure people were protected from abuse or harm because staff knew what to do if they had any concerns.

Registered providers have a responsibility to notify the Care Quality Commission of any abuse or allegations of abuse. Information we received from the local authority highlighted there had been allegations that three people living at the home had been financially abused. The local authority confirmed there was an ongoing formal enquiry in relation to these allegations. However, the CQC had not been notified by the registered provider about these allegations of abuse. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The previous inspection found risk assessments were inconsistent and, in some cases no risk assessments were present. At this inspection we saw one person's care plan had assessments of risk in relation to falls. The falls risk assessment took into account the person's mobility needs, any medical information and history of falls. The use of a hoist was required in order to assist the person to move. The plan detailed the type of hoist to use, the type of sling, the method of sling application and which colour sling to use. This helped to ensure staff used the correct equipment and helped the person to move safely.

However, we found assessments of risk to people continued to be inconsistent and, in some cases, risks had not been assessed. We observed a person eat their food in a way which put them at risk of choking. The staff member assisted the person and reminded them to keep chewing their food and advised the person not to rush. The person's care plan stated, '[Name] tends to eat their food very fast and tends to overfill their mouth and then has trouble swallowing it and has been known to choke so staff have to observe.' However, there was no associated risk assessment in relation to the risk of choking, advising staff of what to do or what actions to take to reduce risk. We shared this concern with the interim manager.

One person, who required assistance from two members of staff in order to transfer from their wheelchair and who was identified as 'high risk of falls,' had no risk assessments in place in relation to falling or moving and handling. Another person, who was identified as requiring two carers to assist them to stand, using

specific equipment, had no moving and handling risk assessment in place. This meant staff had not received appropriate direction in order to assist people to move and the associated risks to people had not been assessed.

The 'Falls' section of one of the care plans we sampled stated, '[Name] is not able to walk and requires full assistance from staff when transferring to bed, chair, commode or wheelchair.' However, there was no moving and handling risk assessment or details to show staff how to safely assist the person. We highlighted this to the interim manager, who told us they were aware some care plans and risk assessments were in need of updating and this was an area they were improving.

The above examples demonstrated a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because assessment of risks to the health and safety of people were not carried out and were therefore not mitigated.

We inspected emergency evacuation plans and we found that only three out of 12 people residing at the home had a personal emergency evacuation plan. This meant some people were placed at risk because the registered provider had not assessed what assistance they may need to exit the home in an emergency.

Following a visit by the West Yorkshire Fire and Rescue Authority, an enforcement notice had been issued to the registered provider of the premises on 18 October 2016. This was because they had failed to comply with a provision / provisions of the Regulatory Reform (Fire Safety) Order 2005 which was issued because people were unsafe in the case of fire. This enforcement notice identified areas which required urgent action. Some areas had been actioned such as staff training and developing a fire risk assessment. However, other areas had not yet been actioned. For example, the enforcement notice had identified the fire resistance in the ground floor suspended ceiling was not providing sufficient protection in case of fire and would affect people before they could escape. The interim manager confirmed work had not yet begun to rectify this but told us the nominated individual was looking to obtain quotes for the required works. The enforcement notice required that the notice be remedied by 9 January 2017.

The above demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because premises were not fit for purpose in line with statutory requirements.

The lift and moving and handling equipment had been recently serviced and gas safety had recently been tested. Portable appliances had been certified as safe. The fire alarms, emergency lighting and the nurse call bell system had been serviced during May 2016. However, the previous inspection found concerns regarding a lack of regular safety checks within the home. This inspection found regular safety checks such as testing fire alarms, emergency lights, call bells and water temperatures had not been undertaken. The interim manager advised they were advertising for a maintenance person who would undertake these tasks but this role had not yet been filled. We were also told at the last inspection the registered provider was in the process of recruiting a maintenance person. This put people at risk because systems were not regularly tested to ensure they were in good working order.

Staff were able to tell us the actions they would take in an emergency, such as a person falling. Each care plan contained a section which related to accidents and incidents. We could see accidents and incidents were recorded and action was taken. However, there was no overview or analysis. By analysing accidents and incidents the manager and registered provider could identify potential triggers or trends and therefore put measures in place to reduce potential incidents. This was also highlighted at our last inspection and had not been acted upon.

The previous inspection found concerns regarding staffing levels. We found an additional member of staff was now deployed and staff told us they felt this was effective. A family member we spoke with told us, "There are always staff around. They always let me in quickly." This family member told us they came to visit the home on different days and most staff faces were familiar. This showed there was continuity of staff. A visiting professional told us, "It's usually the same staff. Sometimes there are staff around. You can wait a while." Another visiting professional told us they felt there were enough staff and said, "Personally I don't have any problems with the staff." A member of staff told us, "The workload's manageable."

We inspected three staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at whether medicines were administered and managed safely. Medicines were administered by staff who had received specific training to do so. We observed a senior carer administer medicines. All the medication administration records (MAR)s we sampled had been signed by the staff member, and these indicated the time of the administration. This helped to ensure medicines were administered at appropriate intervals. The member of staff told people what their medicine was and what it was for and people were supported appropriately with a drink to take their medicine when necessary. The staff member popped pills into a dispenser, without touching the medicine which demonstrated good infection prevention practice.

Some people were prescribed PRN medicines, which are to be administered as and when required. We observed the staff member ask a person whether they required their PRN medicine. We saw the dosette boxes which contained medicines included essential information such as the person's name, number of medicines, directions for administration and time of administration. This helped to reduce the risk or errors. We checked a random sample of medicines and the stock remaining reconciled with the MAR.

One person had refused to take their medicines for a period of time. The person had capacity to make this decision. Staff took appropriate action such as advising the person's GP and recording when the medicines had been offered and the person's decision.

It is important that medicines are stored at the correct temperature. The fridge and room temperatures were checked every shift which reduced the risks associated with medicines being stored incorrectly. A new information recording chart had been introduced by interim manager in order to monitor this.

We saw evidence staff had queried medicines with the pharmacy when they were unsure whether particular medicines should be taken together. This helped to reduce risks to people because staff sought appropriate advice if they considered there may be any risks associated with particular medicines.

The most recent infection control audit, carried out by the local authority for 2016/17, had a score of 96%. People told us staff wore personal protective equipment (PPE) when providing personal care and the staff we asked told us they had access to adequate supplies. We saw staff frequently washed their hands and used anti-bacterial gels. All of the bathrooms we looked in were clean and smelled fresh. Hand-wash and paper towels were available and signs were displayed to encourage effective hand-washing. This helped to prevent and control the risk of the spread of infection.

We saw a number of different types and styles of slings, used to help people to move, were hung on a hook at the end of a corridor. These were not labelled for individuals. We spoke with the interim manager

regarding this who advised they were aware this was poor practice in relation to infection control as well as moving and handling, because staff should use equipment that is specific to people's needs. The interim manager advised this would be raised with staff and moving and handling training was being sourced.

Inadequate

Is the service effective?

Our findings

We asked people whether they felt staff were appropriately trained. A relative told us, "I feel as though staff know what they're doing. They've always had a good attitude."

The previous inspection found concerns regarding a lack of staff training and support. The same was found at this inspection. The interim manager advised they were aware it was difficult to determine what training staff had undertaken, because there was no training matrix and some certificates from previous training had not been issued. The interim manager had sourced a training provider and had arranged for staff to undertake training in safeguarding, moving and handling and dementia care by the end of December 2016. However, at the time of the inspection, it was not clear whether staff had received training in these areas.

Of the three staff files we reviewed, we found staff had received training in moving and handling, food safety, dementia awareness and medication administration and management where appropriate. We could not identify staff had received training in relation to safeguarding adults or the Mental Capacity Act 2005 and the interim manager was unable to confirm this.

One person was being provided assistance with stoma and colostomy care. This is care that is provided following a surgical procedure which results in an opening, known as a stoma, on the person's abdomen. A colostomy bag is then placed over the stoma. We could see no evidence that staff had been trained to provide this type of care and support and there was no specific plan to advise staff of what to do or to identify any associated risks. The interim manager was unclear whether staff had received training in this area of care. We asked a member of care staff and they told us they had not received training but that information was, "Passed on," through other members of staff. This meant staff were providing care and support for which they had not received training and may not have the skills and knowledge to undertake.

The Blossom Care Staff Supervision Policy stated, 'The care service is committed to providing its care staff with formal supervision at least six times a year [the minimum would be four].' Staff told us, and the staff files we reviewed showed, staff had not received formal supervision since May 2015. Furthermore, staff performance had not been reviewed or appraised. The interim manager was aware of this and had begun working on a timetable to provide regular staff supervision.

The above demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff did not receive appropriate support, training, professional development, supervision and appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. One care plan stated, '[Name of relative] is next of kin so anything regarding [Name] needs to be approved by them.' However, the person had capacity to make their own decisions regarding their care and there was no evidence the relative had lasting power of attorney in order to make decisions on the person's behalf. This practice contradicted the principles of the Mental Capacity Act 2005. We asked the interim manager about this and they advised they were aware there was incorrect information in the care plan that needed addressing.

We asked the registered manager whether anyone residing at the home lacked capacity to make any specific decisions. The registered manager told us everyone living at the home could make day to day decisions such as what to eat and what to wear but that some people may lack capacity to make more complex decisions. We were told there were no DoLS authorisations in place and this was an area the interim manager was aware needed examining.

In order for a decision to be made on a person's behalf, in line with the MCA, it must first be established the person lacks capacity to make that decision for themselves. We found some people had decisions made on their behalf, yet we could find no mental capacity assessments in any of the files we sampled. Staff had received specific instructions on what to do regarding a person's particular behaviour, based on a decision which the care plan stated had been made in the person's best interests. However, there was no mental capacity assessment to show the person's capacity had been assessed and there was no date indicated when this might be reviewed. This meant the decision was being made for the person indefinitely. The care plan stated, 'If staff feel uncomfortable with the decision (as a DoL issue) the home will explore a DoL authorisation at that point.' This showed a lack of understanding of the MCA and DoLS. The interim manager advised they were aware that mental capacity assessments had not been completed and this was something they would address. This showed decisions were made on behalf of a person without adhering to the principles of the MCA 2005.

The above demonstrated a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff did not always act in accordance with the Mental Capacity Act 2005.

Staff demonstrated awareness that consent needed to be sought from people in order for care and support to be provided. A member of staff told us, "If [name of person] says no then we respect that."

We looked at whether people's nutritional and hydration needs were met. A person told us, "The food is nice." Another person said, "I enjoy all my meals." The interim manager had devised a cultural menu which meant people at the home could enjoy their preferred food type, according to their cultural preferences.

The cook told us, and we saw, people were given two choices of main meal each day. The cook asked people in the morning what they would like to eat on that day and their choices were accommodated. We observed during a lunchtime, one person did not want to eat what they had chosen. Staff made the person an alternative meal, which the person ate and appeared to enjoy.

We asked the cook how they knew what people's individual dietary requirements were. They told us they did not hold records in the kitchen but they knew people's choices and preferences. We were told, "The old chef told me before they left. It's in my head." We raised this as a concern and the interim manager shared with

us a dietary needs sheet they had introduced on the second day of the inspection, in order that the person cooking was aware of people's dietary needs.

People were weighed monthly and the interim manager had identified two people had recently lost weight. The interim manager had requested staff weigh these people weekly and keep food and fluid charts. Records stated, 'Extra snacks should be offered and their meals must be fortified.' This involves adding nutrients to food in order to boost calorie intake for people who are at risk of malnutrition or weight loss. We asked the cook whether their food was fortified but the cook did not know what this meant. We asked whether any supplements or nutrients were added to their food but were told this was not the case. This meant people's nutritional needs were not being appropriately met. We shared our concern with the interim manager who said the cook had only recently been appointed. The interim manager told us their training needs would be reviewed.

We saw two of the care plans we sampled indicated the people were diabetic and there was no risk assessment associated with this or guidance for staff regarding the implications of diabetes. A professional had visited the home during our inspection and a person's blood sugar level was high. The visiting professional had asked staff why they were serving the person a sweet dessert when they had high blood sugar. A member of staff advised they could not treat the person any differently to other people so they had been given a sweet dessert. However, staff had not considered other options such as sugar free or specific diabetic desserts, in order to provide safe care and treatment for the person with diabetes. The visiting professional raised this concern with the interim manager, who agreed to address this. This showed risks associated with diet and diabetes were not being managed appropriately.

The above demonstrated a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the nutritional needs of service users were not appropriately met.

Following a recent visit from the local authority contracts team, some improvements had been made to the environment, such as flooring being replaced and walls being painted. However, on the first day of our inspection we found a person's bedside light was not working and another person's main bedroom light was not working. One person's bedside light did not have a cover over the bulb. One person's bedroom we viewed had torn wall paper around each of the walls. On the second day of our inspection, the interim manager had arranged for the lights to be repaired. The interim manager told us ongoing improvements were planned.

A visiting professional told us they felt people accessed additional healthcare in a timely manner if this was required. A person we spoke with said, "They always get the GP if needed." We saw people accessed other healthcare services such as podiatry, optician and nurses. A relative we spoke with told us, "They do access the GP or nurse quickly if needed." This demonstrated people living at the home received additional support when required to meet their care and treatment needs.

Good

Is the service caring?

Our findings

We asked people whether staff were caring. One person said, "It's lovely here. Nice comfortable bed. The carers are good. They help me get washed and dressed." Another said, "Staff are nice in here." A further person said, "Right comfortable living here."

A further person told us, "The carers are all okay. I couldn't wish for better carers. All the carers will help. They're all good. No-one's ever been nasty." Another said, "I like the staff here."

A relative told us, "Staff have always been good in attitude. They always offer a cup of tea."

We observed a carer ask a person if they would like assistance to move to a comfy seat, following a meal and the person smiled and said, "Oh, I've never had it so good."

A visiting professional told us, "Staff are caring here. Yes, I think so."

We heard staff speak with people in a respectful manner and in kindly tones. We observed people to look comfortable in the presence of staff and we saw people laughing and joking with staff.

We observed a staff member ask a person whether they wanted a drink. The person did not respond. The staff member therefore appropriately rephrased their question and waited patiently for a response. The person eventually accepted the offer of a drink and gave their preference. Throughout this interaction, the carer showed patience and understanding and gave the person the time they needed to make and communicate their decision.

We heard a person ask a member of staff for a cup of tea. The member of staff queried this with the person and said, "Do you mean coffee? You usually drink coffee?" The person laughed and said, "Yes I do don't I." The member of staff made the person a drink of their choice but this conversation showed the member of staff was aware of the person's usual preferences and sought to clarify this with the person when they were unsure.

A number of people living at the home spoke a language other than English. The interim manager was multi-lingual and was seen and heard conversing with people in different languages. This was done in a relaxed and pleasant manner. A carer was also multi-lingual and this helped to ensure people could communicate in their first language.

Staff explained to us how they tried to maintain people's privacy and dignity, such as by keeping doors and curtains closed when assisting people with personal care. We observed staff knock on people's doors before entering their rooms.

We observed staff were patient with people and when staff assisted people to move, they worked at the person's pace. On one occasion we saw staff assisting a person who was struggling to move. Staff patiently

encouraged the person and then advised the person to remain seated and to try again in a few minutes if they wished. This showed staff enabled the person to be as independent as possible, whilst still providing the support required.

Inadequate

Is the service responsive?

Our findings

We asked people whether they could make their own choices. One person told us, "I usually get what I like. Get a choice for dinner." Another person told us, "I get up at 7.30am. It's my choice."

We looked at care planning information for seven people. The quality of care plans was variable and the interim manager told us they were aware of this. We saw one care plan which detailed the person's life history and background. However, other care plans we sampled lacked this personalised information.

Two people residing at the home did not have a care plan in place. The interim manager told us this was because they had been staying at the home on a temporary basis but they were aware of this and this was something they were working on. Both people had been residing at the home for longer than three weeks. One person was able to walk two to three steps and required the assistance of a carer to transfer safely from one seat to another. This information was contained in an assessment by the local authority. However, there was no care plan or moving and handling plan or risk assessment in place for this person to enable staff to safely assist the person. Information relating to the second person without a care plan indicated they were, 'Unsteady on their feet' but there was no information to guide staff on how to appropriately support the person.

We could not find evidence to show that people's care plans were being regularly reviewed or that people were involved in this process. The interim manager told us they could not be sure whether care plans had been reviewed but this was an area they were looking to improve. A relative we asked told us they had not been involved in any care planning reviews and a person we spoke with confirmed this.

There was a lack of meaningful activities and one person told us, "I get bored. Not much goes on here." We observed people sat passively looking around the room or at the television for long periods of time, as we did at our last inspection. Activities were limited to draughts, dominoes, hula hoop, Kerplunk, connect 4, eye-spy and watching films. The interim manager had identified these were not person centred and advised they were working towards developing improved quality care plans so they could determine people's interests and provide more personalised appropriate activities. The interim manager had developed a new daily handover sheet which included nominating staff who would be responsible for delivering activities on a particular day. We observed some people playing a game of dominoes with staff on the afternoon of the first day of our inspection.

The above demonstrated a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not always carry out an assessment of people's needs and preferences, care and treatment was not designed with a view to achieving people's preferences and people were not involved in decisions.

A visitor told us they felt they could visit the home whenever they wished. There were no restrictions on visitors. This helped to reduce social isolation and helped to ensure people could maintain contact with those important to them.

We saw people being offered choices throughout the day. We observed a member of staff ask a person what they wanted to eat for breakfast. The member of staff prepared the person's preference in the kitchen. We saw people were offered choices such as where to sit and what to eat or drink. One person's care plan indicated they preferred to stay in their room. Although we were unable to communicate verbally with the person, we asked the person whether they were happy and whether we could do anything to help them. The person smiled and nodded and indicated they were happy.

Four of the five bedrooms we viewed had not been personalised. For example, they did not have any photographs on display and no items of sentimental value could be seen. We asked the interim manager about this, who told us people were encouraged to bring their own items into the home. We nevertheless found multiple rooms to be sparse and not personalised or homely.

A relative told us they had never needed to complain. The interim manager told us they were not aware of any complaints. However we saw a complaints policy was in place and the interim manager had implemented a log where complaints and resulting actions could be recorded.

The interim manager had introduced a daily communication log. These were detailed notes and staff recorded relevant daily information regarding people's needs and the support provided. This enabled staff to share relevant information with each other in order to better provide effective care.

Inadequate

Is the service well-led?

Our findings

The registered manager had been absent from work due to maternity leave since March 2016. We had been advised by the registered provider that Blossom Care Home would, 'Run as normal in the absence of [registered manager] and neither residents and staff will be affected.' This was because the registered provider of the home would be present and was familiar with the home, residents and staff.

During September 2016 the registered provider informed us the registered manager's maternity leave had been extended until December 2016 and that Blossom Care Home would continue to, 'Run as normal in absence of [registered manager].' This was because the registered provider would continue to manage Blossom Care Home alongside a Senior Care Assistant who had been employed at the care home since 1996.

During our inspection, we were told by staff and the interim manager that the registered provider was no longer involved in the running of the home and we had been notified an agent had been appointed. At the time of our inspection, an interim manager had been appointed by the agent, and they had been in post for two weeks.

The interim manager told us they felt supported by the agent. However, they were unsure how long they would remain in post.

The Care Quality Commission was aware of some proposed changes to the business in terms of ownership. The home had previously been rated as 'Inadequate' and was, at the time of inspection, still registered with the same registered provider as the last inspection. This inspection considered whether any improvements had been made since the previous inspection.

The previous inspection ratings were displayed. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities.

A relative told us, "I've not met the new manager. Changes have been advised about a month ago, verbally."

A person told us they were aware of some recent changes to the management of the home and said, "It's better for visitors. They've put new tablecloths on."

The previous inspection had found concerns regarding a lack management oversight and staff support. The same was found at this inspection because staff had not received regular supervision or appraisals of their performance. Staff training was not managed and delivered effectively and regularly and regular staff meetings did not take place.

The registered provider did not seek and act on feedback from relevant persons and this was also a concern at the previous inspection. No residents' meetings were held and no reviews of care plans could be evidenced. No quality assurance questionnaires had been sent to people or their relatives. This meant

people's views were not being sought in relation to the service provided. Meetings are an important part of a registered provider's responsibility to ensure information is disseminated to people and staff appropriately and to come to informed views about the service.

At the last inspection we asked to look at emergency plans that were in place for the home. We were given a file which contained emergency plans. However, the file was scant and contained very little information. For example, although the index indicated there were plans in place in the event of fire, flood, power cut, gas leak, equipment breaking down, none of these plans were available to view. We found the same at this inspection. This further demonstrated a lack of management oversight.

The registered provider had been issued with a fire enforcement notice since the last inspection. This raised concerns regarding the safety of the premises and action had not yet been taken to address the issues relating to the safety of the building.

We could find no evidence of audits having taken place. The interim manager advised they were aware of this and had developed some audit tools. These were shared with us and included plans for audits in relation to medication, infection prevention and control, laundry, maintenance and the environment. However, these were not yet in use and audits had not been completed. The previous inspection had also found audits to be weak and incomplete.

There continued to be a lack of information regarding people's care needs such as care plans and risk assessments. Registered providers have a duty to maintain contemporaneous records in respect of people. Due to the lack of management oversight, records were not updated and, in some cases, were none existent. This had also been raised at the previous inspection.

The interim manager had identified there were many outstanding issues at the home and had developed a plan to begin to address these issues. However, the above demonstrated a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the quality and safety of services and the health and safety of people were not assessed and monitored, appropriate records were not kept, feedback from relevant persons was not sought and the registered provider did not evaluate and improve the quality and safety of the service.