Bluewater Care Homes Limited

Bluewater Care 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bluewater Nursing Home is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection. Some people were living with dementia. The service can support up to 60 people. Although it is called 'nursing home', it does not provide nursing care.

The home is based on four floors with an interconnecting passenger lift. The ground floor provides communal areas for people and the first, second and third floors provide bedrooms, communal bathrooms and a small communal area. Only the lower two floors were in use at the time of the inspection.

People's experience of using this service and what we found
The provider did not ensure that risks to people's health, safety and wellbeing were assessed and managed, which put people at increased risk of avoidable harm. Decisions made to manage people's risks were not consistently clear or in line with national guidance, were not always safe and were not always the least restrictive. Medicines were not always well managed or stored in line with requirements. People's medicines care plans did not have clear information for 'as needed' medicines.

Recruitment processes were not robust and did not always ensure staff were suitable to work with people who use care services. There were enough staff to deployed to keep people safe. Staff were busy throughout the inspection, moving from task to task. Although staff had an understanding of safeguarding and knew how to report concerns, we were alerted to bruising to one person which had not been properly reported to the local authority. Improvements had been made in reporting incidents, however incidents related to behaviours which may challenge staff were not consistently reported and reviewed for learning and improving care.

The provider had made improvements to infection prevention and control in the home, which was visibly clean and staff were wearing appropriate personal protective equipment (PPE).

People were not supported to have maximum choice and control of their lives and we were not assured staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's capacity to consent or to make decisions was not always properly assessed. It was not clear the provider had followed the principles of the Mental Capacity Act 2005 and that decisions made in people's best interest appropriately considered the pros, cons and alternatives related to the decision, or were the least restrictive.

We could not be assured that people were always offered or received enough to drink. People's risks related to malnutrition had been assessed, however care plans were not always clear where nutrition was a priority over other risks related to eating and drinking.

Improvements had been made in staff completing training and understanding of topics relevant to their

role, such as mental capacity, risk and safeguarding. We raised some concerns over the number of courses staff had completed in one day, which we highlighted to the manager.

The provider had not taken a systematic and proactive approach to identifying and addressing quality and safety issues. On inspection we identified risks to the health, safety and wellbeing of people which had not been identified by the provider, despite checks, reviews and audits which should have identified them, or which had been signed off as completed in an action plan.

Staff and relatives fed back that there had been some improvements since the last inspection. Staff felt that some staff, who were not providing good quality care, had left. Staff fed back positively about the new manager.

Some improvements had been made in response to previous inspections and in response to external audits of the home. These included improvements in staff approach to people, in the cleanliness of the building, the introduction of resident and relatives' meetings and the introduction of champion roles for staff. Relatives mostly fed back positively about the staff in the home, with some relatives naming specific staff to praise their patience and kindness.

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

Rating at last inspection
The last rating for this service was inadequate (19 May 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found some improvements had been made and some breaches of regulations had been resolved, however in other areas improvements had not been sufficient and the provider was still in breach of five regulations.

This service has been in special measures since 19 May 2021.

Why we inspected
We carried out an unannounced inspection of this service on 25 March – 15 April 2021 and identified breaches of legal requirements related to respect and dignity; consent; safe care and treatment; nutrition and hydration; good governance; fit and proper persons employed and duty of candour. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, effective and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remained inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to consent; safe care and treatment; nutrition and hydration; good governance and fit and proper persons employed at this inspection.

Following this inspection, we cancelled the provider's registration.

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

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Bluewater Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector and a pharmacist specialist on site. Two inspectors and an Expert by Experience supported the inspection remotely. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

At the time of the inspection there was no registered manager. The service had a manager in post who was preparing to register with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

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

During the inspection
We spoke with five people who used the service and eight relatives about their experience of the care provided. We spoke with 12 members of staff including the manager, head of care, care workers, housekeeper and the chef. We observed how staff interacted with people and how people were supported during a mealtime.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. The provider submitted further evidence after the inspection, which we considered as part of this report and in making our judgements.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At previous inspections, we found that risks were not always appropriately assessed and managed, this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously, we found that information on specific health conditions and how they impacted people's health and care needs was not always present. People did not always receive food modified to the appropriate textures based on their records, and information on dietary needs was not consistent or available to staff. There were concerns over bowel management, re-positioning, management of falls risks and use of a fogging machine (a machine used to decontaminate a room using chemicals).

At this inspection we found not enough improvement had been made and the provider remained in breach of this regulation.

● Risks to people's health, safety and wellbeing were not consistently assessed and did not always have robust, clear management plans in place to mitigate known risks. Some care plans did not evidence how decisions had been made related to risk and decisions did not follow best practice or national guidelines. This placed people at increased risk of avoidable harm.
● During the inspection, visiting professionals identified that bed rails were in place for one resident, which had been put in place the previous day. The person had involuntary movements which put them at increased risk of harm from bedrails. The bed rails were also not suitable for the person's bed and had an unsafe gap between the bed and mattress. Ill-fitting bed rails pose a risk of entrapment for residents which can result in serious harm or death.
●One person's re-positioning schedule to reduce their risk of pressure ulcers was not regular or in line with national guidance. The provider confirmed they updated this person's care plan after the inspection.
● Another person had been assessed as very high risk of pressure ulcers. Their pressure ulcer care plan stated they could move themselves in bed, however, in their moving and handling care plan, it stated they sometimes could not move independently in bed and needed support from staff. They did not have a re-positioning schedule in line with NICE guidance to encourage or support them to change position at least every four hours. This person was at increased risk of pressure ulcers as staff did not have prompts or guidance to support the person to regularly change position.
● It was unclear from daily recording by staff that care plans had been consistently followed in practice, which put people at increased risk of harm. For example, records showed staff re-positioned people but put them into the same position on consecutive occasions. Although the people whose records we reviewed had not developed pressure ulcers since the last inspection, they were at increased risk of developing a

pressure ulcer due to long periods in the same position.

● Although, on inspection, we observed foods had been prepared in line with people's requirements, based on their choking risk; we could not be assured from daily care records that this had been consistent prior to the inspection. Records documented that people's meals had not been consistently prepared in line with their requirements due to their risk of choking.

● For example, one person had been placed onto a pureed diet by the home, in agreement with the speech and language therapist (SALT). The daily care records noted at times their food was prepared to "soft" consistency after this decision throughout the five weeks of records seen. Their food charts recorded they had sandwiches and buttered bread, which would put them at risk of choking. After the inspection the provider contacted the SALT team to agree what is safe for the person to eat. They made recommendations for the service to update the person's capacity assessment and ensure the risks and considerations are reflected in any best interest decision. They recommended the provider update their care plan to ensure the person is supervised if they have food which is not pureed.

● People's care plans did not always include clear risk management guidance for staff. We identified some aspects of care plans were unclear or did not contain enough information, which could lead to inconsistency in how staff managed risks. Examples included inconsistent guidance on moving and handling techniques and equipment, a lack of detail for identifying when someone's behaviours may indicate they are distressed or upset, and how staff should managing this, and lack of clear guidance on managing risk of malnutrition. The provider told us they updated one person's moving and handling guidance after the inspection following confirmation with the Occupational Therapist of their advice from a review in August 2021.

● Staff told us they took different approaches in managing people's needs, which did not always reflect the care plan. Staff told us they had different strategies for managing behaviours which could indicate people were distressed, which led to an inconsistent approach. These incidents were not captured, which meant it was difficult to identify trends, triggers or effective management strategies and include these in a care plan for staff to follow.

● We could not always be assured that risks were managed in the least restrictive way as mental capacity assessments and best interest decisions were not always evident. Where they were recorded, it was not clear that there was appropriate consideration of pros and cons of a decision or consideration of appropriate alternatives to decisions which could impact someone's freedom of movement or privacy. Examples included decisions to use bed rails, decisions to have locked doors and the use of CCTV in the home.

● Some issues identified on previous inspections had been addressed by the provider. For example, a kettle which posed a risk of scalding to residents was stored in a locked cupboard between uses. However other aspects of health and safety of the building and equipment were not risk assessed to ensure they were safe. For example, two residents were located in a room next to a stairwell, with no restriction to their access to the stairwell. Both required supervision or assistance from a member of staff when mobilising, and one was living with dementia. There was a locked door with a keypad to access their room and stairwell from the main corridor, where staff were located, which could delay staff intervening should a person access the stairwell. This presented a risk of falls, particularly at night when staffing levels are reduced, should the residents become disorientated or confused.

● We identified hazards and obstructions on the top floor which could affect access to a fire lift or obstruct evacuation. Though no people were living on this floor, it was evident, and we were later told, that staff sometimes slept on this floor, which the manager was not aware of. We observed some fire doors did not close, though these were unused bedrooms, one door by a stairwell had a broken handle, one bedroom door was propped open and another door's automatic release was taped open. Following a conversation with the Fire Service, they undertook an audit of the home on 12 November 2021. They identified some issues, including two fire doors, items in the corridor on the third floor and a lack of detection in one room on the ground floor. The issues were resolved by 16 November 2021, to the satisfaction of the Fire Officer.

● Other hazards were identified to the manager included a broken window restrictor and opening mechanism on one window on the top floor which was unsafe. We found equipment and other items, including fire resistant expanding foam, in an unlocked cupboard in the "train", an activity area on the ground floor. This posed a risk to people who may be confused.
● Some improvements had been made in response to previous concerns regarding how risks were assessed and managed. People's care records now contained information on their health conditions.. However, improvements were not consistent for all people living in the home.

Failure to appropriately assess and manage risks to people is an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection we identified that medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvements had been made and the provider remained in breach of this regulation.

● Electronic Medicines Administration Records (MARs) had been suspended and the service had reverted to paper records. People's allergy information was recorded in their care plans, but some MAR records were blank related to allergies, rather than having "no known allergies" recorded which meant it was unclear if the person had no allergies, or there was a records error. The provider told us they were taking action to ensure the records were updated with the pharmacy.
● Where people had 'as needed' (PRN) medicines, people did not always have clear protocols for staff on when to administer the medication and when to seek medical advice in line with NICE guidance. Some PRN protocols were absent. This meant that staff might not administer medicines these medicines consistently, reducing the effectiveness of the medicines. We saw one example where a person had experienced constipation and, though they had been given one dose of PRN medication, this had not been effective, and no further doses were administered. We were not, therefore, assured that PRN medicines were being managed safely and effectively.
● Whilst staff signed that they administered medicines, they did not record the specific dose administered where a variable dose was prescribed. This is important to monitor medicines' effectiveness and ensure people are not given more than the maximum dose in 24 hours. After the inspection the provider sent us an example of a record put in place to record the variable dose given.
● Staff maintained a rolling stock balance; however, these were not always accurate with the number of doses to be administered during the day. This meant that staff could not be clear on the total dose given of a treatment, errors could not be identified as easily, and missing medication could not be identified.
● Medicines were generally stored securely. Records indicated medicines requiring refrigeration were kept within their recommended temperature range. However, controlled drugs (medicines that require additional controls because of their potential for misuse) were not stored securely, in line with legislation. Room temperatures were monitored where medicines were stored. Where fridge temperatures had gone outside of safe storage limits, records did not include actions taken.
● One person's regular medicine ran out mid-month and the medicine was not available to be administered. This person had an alternative medicine prescribed for the same condition, but prescribed as PRN, which was available during this time. However, we could not see any evidence the provider had sought advice from the person's GP or pharmacy on how to manage the person's condition and gap in regular medication, and we were not assured this had been managed safely by the provider.

Failure to ensure proper and safe management of medicines is an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

At the last inspection, recruitment processes were not robust and did not ensure those employed were suitable to work with people receiving care. This is an ongoing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we found that some improvements had been made, however all aspects of the regulation had not been met and the provider remained in breach.

● We could not be assured that recruitment processes were robust to ensure staff were suitable to work with people. Although some recruitment processes had improved, one of three staff files reviewed did not have all of the required pre-employment checks in place before the member of staff was deployed.
● Providers are required to ensure they have obtained a full employment history, satisfactory evidence of the applicant's conduct in their previous employment in health or social care, and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
● The staff member had a DBS check which was returned after they started work. Not all relevant references were evidenced in records seen and one gap in their employment history did not have an explanation. Although there was a risk assessment related to their employment prior to their DBS check – this did not reflect the requirements of the interim guidance on recruiting during the COVID-19 pandemic. The risk assessment did not evidence urgent need for the member of staff, or additional measures to reduce the risks to people, such as additional supervision or shadowing prior to the DBS being processed.

Failure to ensure recruitment processes were robust and ensure those employed were suitable to work with people receiving care was an ongoing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the days of the inspection there appeared to be enough staff to keep people safe. There were times people had to wait a short time, and one person waited 20 minutes for their meal, which was re-heated in the microwave. Some people fed back that they felt there were not enough staff, most people felt staff responded when they called. We observed staff were busy and were moving swiftly from task to task.
● The head of care completed the rotas and ensured staff on duty had the relevant training.

Preventing and controlling infection

On a previous inspection, we found that personal protective equipment (PPE) was not always used appropriately and visitors were not prevented during an outbreak. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was no longer in breach of this aspect of Regulation 12.

● We identified some storerooms where items were on the floor, including the clean laundry, which was not in line with good practice.
● On the inspection, the inspection team were asked to complete questions related to COVID-19 prior to

entry, however the answers were not checked by the staff member who let us in. We identified that it would be beneficial to ensure the staff member signing in visitors checked to ensure they were safe to enter, particularly with changes in law which requires COVID-19 vaccination as a condition of deployment for visiting professionals, volunteers and contractors.

We recommend the provider reviews and implements a more robust procedure for signing in visitors and visiting professionals to the home to ensure this is managed safely.

● Overall, the home was visibly clean. We observed staff were wearing appropriate PPE. There was a recent external audit carried out by commissioners of infection control which highlighted improvements had been made.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong

At the last inspection we identified that incidents were not consistently reported and learnt from. Failure to effectively assess, monitor and improve the safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvements had been made and this part of regulation 17 was now met.

● Incident reporting had improved since the last inspection, implementation of the "clinical risk meeting" and attendance of the manager at handovers meant information about incidents was more consistently escalated and discussed.
● Improvement was still needed in reporting incidents related to behaviour which may challenge in order to identify themes, trends, triggers and approaches which could be implemented to reduce behavioural incidents and support staff.

Systems and processes to safeguard people from the risk of abuse
● Staff had a good understanding of types of abuse and how to report it. There was a safeguarding policy and procedure in place. In the records reviewed, we could see that concerns had been reported to the local authority and CQC as needed.
● However, on the inspection the visiting professionals from the care homes team raised a concern regarding bruising to one person. Though one bruise had been reported to the local authority safeguarding team, there were several others which we could not see had been reported. The manager was investigating this incident.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question is now rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the MCA.

At the last inspection we identified that the provider was not always obtaining consent from people who had capacity to consent. Where there was reason, capacity was not always appropriately assessed and decisions made were not always evidenced to be in people's best interests, following the principles of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, though we found some improvements had been made, the provider remained in breach of this regulation.

- We could not be assured that people's consent was always sought, that their capacity to consent was consistently assessed, where appropriate, and that decisions made for people were always in their best interests.
- Some capacity assessments referenced within care plans, or which we would expect to see related to decisions about care, were not present in people's care plans.
- Some mental capacity assessments were well recorded and evidenced how people had been supported to have the right information, or how it had been deemed they lacked capacity to make a decision. However, the quality was not consistent, and some decisions did not have relevant or robust capacity assessments and best interest decisions recorded.

● The day prior to the inspection, the provider made the decision to use full length bed rails for one person following injuries sustained from previous equipment. We reviewed the mental capacity assessment. The capacity assessment was not adequate to evidence the provider had assessed the person's capacity to consent to the use of bed rails or whether they had consented if they did have capacity. The record did not adequately evidence that the pros and cons were weighed up, or that less restrictive and safer alternatives were considered as part of making this decision. Subsequently the bed rails were removed and a low bed with a crash mat was put in place, following intervention by visiting professionals.
● One person's capacity assessments for decisions reflected a lack of consistency in their ability to understand and retain the information, some did not evidence what was discussed and how they responded, or alternatives considered. If the person's capacity is variable or has changed, their capacity to consent should be re-assessed when they are most able to contribute to or make the decision.
● Another person had capacity assessments for some decisions contained within the care plan document sent. The provider had completed a capacity assessment to consent to the use of CCTV in the home. The capacity assessment stated the alternatives considered were that the person may choose not to spend time in the communal areas of the home where there are CCTV cameras present. This is not an appropriate or realistic alternative and would encroach on their human rights.
● The provider had completed a capacity assessment to consent to locked doors with keypads throughout the home. The pros and cons considered were not clear and included people's safety from "outsiders". People could be kept safe from people entering the building without restricting access to communal areas. The provider did not evidence consideration of alternatives, other than people not living at this home.
● It was therefore not always clear that decisions were made in people's best interests when they lacked capacity to make the decision for themselves and that the provider had attempted to find less restrictive options to keep people safe.

Failure to ensure consent was obtained from people who had consent, appropriate assess people's capacity and evidence decisions made for people are in their best interest is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff had training in the Mental Capacity Act and in obtaining consent. Staff we spoke with had an understanding of capacity and how to ask people for consent, staff understood if people may lack capacity this would be assessed, but this would be for managers to do.

Supporting people to eat and drink enough to maintain a balanced diet

At the last inspection, we identified that people were not always supported to have enough food and drink to maintain adequate nutrition and hydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that, although some improvements had been made, these were not enough to ensure all people were supported to manage their risks from malnutrition or dehydration. The provider remained in breach of this regulation.

● The provider used the malnutrition universal screening tool (MUST), these were regularly completed. Where the provider was unable to weigh someone, usually due to a change in their mobility, they used a mid-upper arm circumference (MUAC). This measurement can indicate risk of malnutrition and any reduction would indicate the person may have lost weight and could be experiencing malnutrition. Where this measurement was used, the electronic system used by the provider used the measurement to identify risk - however the risk calculated was lower than when the person had been weighed, which was more

accurate. The system did not appear to automatically flag increased risk when someone's measurement decreased, and this had not been identified by the provider and escalated to relevant professionals.
● One person was not able to be weighed - their arm measurement had decreased from 28.5cm to 24cm - this was not identified as increasing their risk. They were then able to be weighed after this reduction. This identified they had lost 1.7kg (3% of their weight) in 3 months. Their risk assessment then reflected they were now "high risk". At the multidisciplinary team meeting (MDT) with healthcare professionals after this weight loss the notes state, "Patient on level 4 puree diet due to loose-fitting dentures. Weight increasing and eating well." It is the responsibility of the provider to ensure other professionals have the relevant information to manage people's health appropriately.
● Another person at risk of malnutrition was also unable to be weighed. Her arm measurement dropped from 23 to 19cm. There was no evidence this was escalated at the MDT after this change. Their measurement then went up to 23cm and back down to 21cm. Throughout these changes the records system indicated "medium risk. There was no evidence the change in measurement, and potential weight loss, was escalated to relevant healthcare professionals.
● We identified one person's care plan around eating and drinking was not clear for staff on how to prioritise managing their risks. Their risk of malnutrition had not been correctly calculated, care plans stated their risk was medium or low in different parts, where their weight and weight loss would indicate it is high. The person was identified as at risk of choking and they were at risk of malnutrition. The person had mental capacity to make decisions about this and had chosen not to have thickened fluids. The manager told us, and notes from multidisciplinary team meetings indicated, the highest risk for this person was of malnutrition, and that measures in place to reduce their risk of choking were, at times, discouraging them from eating. Their care plan did not clearly identify gaining or maintaining their weight as a goal. This was not clearly reflected in their care plan which meant the person was at increased risk of malnutrition.
● We saw improvements in offering food and fluids to one resident where this had been a focus after concerns were raised previously, and records showed they had been offered enough most days. The deputy manager had focussed on fluid intake and encouraging staff to offer drinks at every opportunity. For other residents reviewed, there remained were several days each week in the records seen where they were not offered enough to drink to meet their target. We could therefore not be assured the provider had enough oversight to ensure people were being offered enough to drink each day.
● Nutritional supplement drinks were offered as prescribed and recorded in medicines administration (MAR) charts. However, for one person, some days the drink was only offered once, and when the offered drink was declined, it was not recorded that this was offered again later in the day where the person was prescribed one to two drinks per day. Staff told us they had been reminded to record whenever foods or drinks were offered and described managing this person's eating and drinking as "very difficult".

Failing to ensure people's nutrition and hydration needs are met is a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people told us the food was good and that they enjoyed it. People had a positive dining experience, and those that needed help had support in place.
● The chef had training in modifying food textures in line with national guidance. Foods with a modified texture were presented in an appealing way. There was a clear information sheet for staff on people's eating and drinking requirements which was up to date based on people's care plans. Dietary information sheets were displayed in areas where food and drinks were prepared.
● On the first day of inspection people did not know what meal options were available. One person told us, "Nobody ever tells me." We highlighted this to staff they were unsure what was available but went to get people a pictorial menu, and we saw staff gave people menus the following day.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessment templates used reflected recognised tools and national guidance, such as assessments of pressure ulcer risks. However, there were some aspects of assessments which did not follow national guidance or best practice, such as following Medicines and Healthcare products Regulatory Agency (MHRA) guidance on safe use of bedrails.
● Another person, who presented with behaviours which challenged staff, did not have a support plan to enable staff to understand triggers and how best to manage this.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care.

At the last inspection we found the provider had failed to work with or obtain timely treatment from relevant medical professionals. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider remained in breach of this regulation.

● The provider did not support staff to follow professional guidance as this was not always reflected in people's care plans or medicines records. Some medication protocols and care plans did not have clear triggers for staff to prompt them to seek medical advice. Though some care plans and care records reflected professional guidance, others were not consistent with or did not contain evidence of agreed professional guidance.
● Examples included one person's eating and drinking care plan and daily care records showed they were having foods which did not reflect the modified texture diet recommended by speech and language therapist. Another person's records did not demonstrate higher risk foods they were eating had been agreed as safe with a speech and language therapist, where they were on a modified diet, in line with national guidance. One person's care plan did not reflect guidance by an occupational therapist on how to safely move them.
● One person had a long-term condition as well as risk of malnutrition. Their health condition meant their weight could fluctuate based on swelling, with swelling one indication that their health condition could be deteriorating, which was identified in their care plan. Records for this person indicated increases and decreases to their weight which were not consistently recorded in the "weight" section of the care plan. It is unclear if this was inaccurate recording, or actual fluctuation in weight. This was not identified by the provider. Though the person's weight was discussed with healthcare professionals, this rapid fluctuation was not discussed or reviewed for validity.
● Two people's weights were being monitored through arm measurement, and we could not see the changes in these measurements, indicating weight loss, had been discussed with relevant professionals within or outside of regular multidisciplinary meetings.

Failure to ensure people had access to timely medical support and failure to work effectively with healthcare professionals to monitor people's health is a continued breach of Regulation 12 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was good support available from professionals into the home, including the local care homes team and through regular multidisciplinary team review meetings.
● Staff told us that the manager attending their shift handovers had improved escalation of any concerns they had about people's needs. We saw some examples where people had been referred to other healthcare

services that they may need, such as a podiatrist or occupational therapist.
● People had oral care plans and regular monitoring of their weight. People's risk assessments related to their skin and nutrition were regularly updated. People's care plans reflected goals, such as daily fluid intake, maintaining independence and their wishes to be involved in decisions. Care plans could have clearer weight and nutrition goals in line with NICE guidance.

Staff support: induction, training, skills and experience

At the last inspection we could not be assured that staff had the appropriate knowledge and skills to safely meet people's needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvements had been made and the provider was no longer in breach of this part of the regulation.

● Increased numbers of staff had completed the required training. In the initial training records we were sent, there remained some gaps in training for staff, however the manager stated this is an area they were working on. We were sent an updated training matrix after the site visit which showed further improvement in completion.
● The manager had started workshops for staff to upskill them in specific areas identified. Staff had a reasonable understanding of topics such as safeguarding, capacity and people's risks.
● We had some concerns over how staff were completing online training courses training records we were sent showed some staff had completed a large number of training courses in one day. One staff member had completed 37 courses in one day, another 35 courses, another 33 courses and another 32 courses. One member of staff was observed in their moving and handling techniques prior to their training, and another member of staff had signed off staff medicines competencies but was overdue to refresh their medicines training. This was highlighted to the manager who said they would look into it.

Adapting service, design, decoration to meet people's needs
● Aspects of the environment were suitable to meet people's needs, such as the large dining and living areas and café areas on the bedroom floors. The hair salon, ice cream parlour, train, cinema and aeroplane areas were also positive to support people with dementia to have an immersive activity, though we did not see these in use during the inspection.
● People living at the service had been provided the code to the lift in a guide on the service, however not all people living at the home could remember a key code. Keypads did not have codes displayed and the keypad in the lift was out of reach to people in a wheelchair. It would benefit people who are otherwise able to move around the home independently to be able to use the lift and access communal areas of the home without the assistance of staff.
● One person had a mini-fridge in their room which supported them to access snacks as they wished. Previous inspections identified people had a choice about the décor of their rooms.
● Some aspects of the home décor were reflective of dementia friendly guidance, such as pictorial signs on toilets and signs towards living areas. There were contrasting colours used for different surfaces, including different coloured carpets to walls.
● Some décor choices could be disorientating to those with dementia - such as painted clowns in the living space and a full-sized rowing boat with model fishermen on the roof in the garden.
● The garden area needed some improvements to ensure it was safe and accessible for people. Even though it was moving into winter, as the only outdoor space for most people in the home, it would benefit people's wellbeing to be able to access the garden if they wished. The wheelchair lift to the garden was obstructed

and there was a ladder in the garden, which would pose a risk to people. Not all seating in the garden was suitable for people with any mobility issues. Doors to the enclosed garden were locked during the inspection.

We recommend the service reviews national dementia friendly guidance related to adjust these aspects of the décor.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection, we found records were not always up to date, accurate and consistent. It was also identified that audits and quality assurance arrangements in place were not sufficiently robust to identify and address issues otherwise identified on the inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found, although some improvements had been made following the last inspection, issues remained with records and with quality assurance measures which was a continued breach of this regulation.

At a previous inspection, we found that not all incidents which met the requirement to be reported to CQC had been reported. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found this had improved and notifications had been submitted as required, the provider was no longer in breach of this regulation.

● The provider did not have a systematic approach to reviewing and managing risks to health, safety and welfare of people. Although three breaches of regulations had been resolved, five regulations were still in breach. Since the provider registered the location, they have failed to achieve an overall rating of good. We could not be assured that management understood the principles of good quality assurance and that, despite efforts, external support from professionals and sufficient time, the provider's approach remained reactive to external feedback.
● A new manager had been recruited and had been in post for just over three weeks when we undertook a site visit. Although they had taken some action to make improvements, they had not undertaken a full review of the service to understand what improvements were needed. Action plans sent to us focussed mainly on improvements which had been identified through external audits and inspection. Some actions were marked as "complete" when they had not been completed. Where an issue had been identified related to one person, this was not always learnt from to ensure similar issues did not occur related to others.
● We could not be assured that audits and measures in place were effectively identifying and addressing quality and safety issues in the home. Although there was a governance structure in place with regular

reviews of different aspects of quality and safety, this was not fully embedded, and parts were not robust. For example, daily "walk arounds" introduced by the current manager, weekly fire safety checks and monthly health and safety audits had not identified hazards that the inspection team identified – such as obstructions on the third floor, issues with some fire doors, items stored on floors of store rooms, and inappropriate storage of fire-proof foam in the living area.
● Staff needed strong, clear leadership in managing risks to people. This was demonstrated by the differences in staff approach, and the inconsistencies or lack of clarity when decisions were made related to risks to people.
● People's records were not always maintained to be accurate and complete and were not subject to adequate scrutiny to ensure that issues or errors were identified and resolved. Examples have been highlighted under the safe and effective domains. The manager advised us that they had introduced "resident of the day", however there was no detailed audit of people's care plans and risk assessments, or their daily records to ensure the care provided was safe and effective.

Failure to ensure processes are in place to assess, monitor and improve quality and safety, effectively assess and manage risks to health, safety and wellbeing and failure to maintain accurate and complete records for people is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some improvements had been made following the previous inspections, such as improvement in infection prevention and control, the cleanliness of the building, staff approach towards people, staff training compliance and staff knowledge and understanding of key areas, such as safeguarding or mental capacity.
● The manager had introduced further champion roles and staff were undertaking training and development to take on these roles. The manager reflected they wanted to make improvements and develop the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the previous inspection, we identified that people were not always treated with dignity and people's privacy was not always maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we some improvements had been made and the provider was no longer in breach of this regulation.

● Four of the care staff we spoke with said there had been improvements in the staff team with some staff who were not delivering good care having left. Staff felt there had been improvements since the last inspection. There appeared to be an improved culture within the staff team in terms of their approach. Staff cared about their role and spoke about people respectfully.
● We observed one occasion where a member of staff spoke of someone's condition loudly in a communal area. We highlighted this to the manager who agreed to address this with the member of staff. The manager and staff told us they had had a workshop focussed on language used and upholding dignity to improve in this area. We observed other occasions where staff were very patient, kind and supportive to people.
● We also identified one bathroom door on the first floor which had a large gap when closed. Someone stood in the corridor could clearly see the toilet when the door was shut. We highlighted this to the manager who told us that they were getting quotes to change this door, and that people did not routinely use this

toilet as they had toilets in their en suites. After the inspection the provider confirmed they had completed works to cover the door gap.
● Relatives had mostly positive feedback about the improvements made and the home, one relative was concerned over being identified for giving negative feedback. Two relatives commented on either personal items going missing, or their relative sometimes being in other people's clothes.
● There was positive feedback from staff about the manager in place and they felt attendance at handover was helpful for them. People and their relatives fed back mostly positively about staff, most said staff were nice, were patient and kind. We received very positive feedback about specific staff and their approach. We observed staff were deployed in communal areas and on the first floor to be able to respond to people's needs. We observed staff were responsive and patient in their approach with people, though appeared busy. Some people told us, and we observed, they had to wait at times for staff to be available.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the last inspection we identified the provider was not acting on their duty of candour when things went wrong. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was no longer in breach of this regulation.
● We saw evidence of the service giving an apology and explanation for an incident since the last inspection, we did not identify any incidents which would meet the threshold for duty of candour which had not been acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We could see that the service had re-instated regular residents' meetings to gain feedback and that suggestions had been acted upon. The manager had also recently introduced a relatives committee which meant relatives could meet without home staff and feedback to the management team. Relatives fed back that communication had improved, and they had more regular updates on their relative's care.
● Staff told us the new manager was approachable and told us of improvements the manager had introduced, such as the resident of the day initiative. There were staff champion roles, which the service was adding to. Staff were aware of key areas which had been a focus for improvement, such as medicines. The provider told us of one initiative staff had suggested, to implement 'laughter champions', to focus on people's experience and wellbeing. However, we found no other examples where the provider had sought and acted upon staff feedback to drive improvement.

Working in partnership with others
● The service had regular multidisciplinary team meetings with external healthcare professionals who provided good support to the home in managing people's needs.
● We saw that some responses to past feedback has been defensive and did not always acknowledge issues identified by external stakeholders, however other stakeholder feedback had been acted upon, such as the infection prevention and control audits.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure consent was sought from people who had capacity to consent, that people's capacity was appropriately assessed and that decisions made were in people's best interests.

The enforcement action we took:

We cancelled 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 provider had failed to appropriately assess and manage risks to people's health, safety and wellbeing, failed to manage medicines safely and failed to work with healthcare professionals to provide timely and effective care.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure people were consistently given enough to drink, and failed to ensure people's risk of malnutrition was understood and prioritised by staff.

The enforcement action we took:

We cancelled 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 provider has failed to implement a robust

process to assess and take action on issues effecting the quality and safety of the service. Records were not always complete, accurate and up to date.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to undertake appropriate pre-employment checks in line with Schedule 3.

The enforcement action we took:

We cancelled the provider's registration.