Southwark Park Nursing Homes Limited

Blenheim Care Centres

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

Summary of findings

Overall summary

The inspection took place on 4 September 2017 and was unannounced.

Blenheim Care Centres is a nursing and residential care home for up to 80 people located near to Gainsborough, West Lincolnshire. The home is divided in to three units, Blenheim House, Blenheim Lodge and some semi-independent flats. Blenheim Lodge was closed on the day of our inspection. The home caters for people whose ages range from 18 years and above, and who have physical disabilities and/or neurological conditions. On the day of our inspection 21 people were living at the home, 12 of these people received nursing care.

An unannounced comprehensive inspection was carried out on 9 August 2016 during which we identified five breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to medicines arrangements, risk assessments, the environment, infection control and prevention, governance, staffing levels and capacity assessments. At two further inspections we found that although the registered provider had taken some actions, they had not made sufficient progress to become compliant with legal requirements and improvements had not been tested for sustainability. We completed a further comprehensive inspection on 21 February 2017 where we identified that there still concerns related to medicines management, risk assessments, completeness of care plans, staffing levels and mental capacity assessments. The home was placed into special measures after this inspection.

At out inspection on 4 September 2017 we found that the provider had failed to make the improvements needed and the overall rating for this home is Inadequate and the home remains in special measures.

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

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the home 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.

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

The premises of the home were not maintained to a standard which supported people's wellbeing and the delivery of person centred care. The provider had failed to develop a plan to support the refurbishment of the building to an appropriate standard. The quality monitoring of the home failed to give an accurate view of all the improvements needed and where improvements were identified inadequate action plans meant that appropriate action was not taken. This followed a pattern as the provider, who was the sole director of the company was also the sole director and person with significant control for two other providers each with a single home. The Care Quality Commission had identified significant concerns in one home and need for improvement in the other.

There was not enough staff employed at the home to meet people's needs and consequently there was a reliance on agency staff to fulfil both nursing and caring roles. The registered manager had not employed enough staff to fill the gaps in the rota. The registered manager had not used the needs of the people living at the home to inform the number of staff required to provide safe care for people. Appropriate checks had been completed for new staff to ensure they were safe to work with vulnerable people. Training had been provided for staff but this had not been reinforced with regular supervisions to support staff.

People's care plans ensured that the care provided was safe and that they had their physical needs met safely. However, risk assessments were not always in place to protect people's emotional needs and information about emotional needs were missing for the care plans. People's medicines were given to them in a safe manner but people were not always supported to take their medicines as prescribed when they were away from the care home. People's privacy and dignity was not fully respected and people had not been supported to access the hairdresser or chiropodist on a regular basis.

People's wellbeing was not supported by the activities offered to them and some people chose not to take part in the planned activities. People had raised concerns about the activities in a survey in July 2017 but no action had been taken to improve the day to day activities.

Where people had been unable to make the decision to live at the home the provider had submitted appropriate applications for assessment under the Deprivation of Liberty Safeguards. Where people were not able to make decisions for themselves decisions had been taken in their best interest. However the recording of assessments was not clear and the registered manager had not taken into account how alcohol may affect people's ability to make decision. People were able to make some decisions about their everyday lives but sometimes care was limited by the availability of staff.

Staff knew how to raise any safeguarding concerns but people were not always provided with somewhere safe to store their valuables. The registered manager investigated safeguarding concerns and took appropriate action. People living at the home were happy to raise any concerns and complaints with the registered manager or staff.

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.

The registered provider had not ensured that there were enough skilled and knowledgeable staff to provide safe consistent care.

People were not always supported to take their medicines when they were in the community.

Risks to people were not fully identified or managed.

People felt safe living at the home and the registered manager responded to concerns.

Is the service effective?

Inadequate

The service was not effective.

The premises were not adequately maintained to support people's wellbeing and dignity.

The registered manager had not fully understood how alcohol could affect people's ability to make decisions.

People were offered a choice of food.

People were supported to access the doctors and hospital when needed but had not been supported to access a chiropodist as frequently as recorded in their care plans.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was not fully respected.

There was a kind and caring relationship between staff and people living at the home and staff supported people even when they were not at work.

People understood their right to access and advocate.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not fully support people's wellbeing

People were involved in planning their care.

People where clear on how to raise a complaint.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have systems in place to support the care in the home to improve. Records showed that a number of the provider's homes were failing.

There was some confusion about the status of the people living in the flats.

Audits were ineffective and did not support the quality of care to improve.

People's views on the service were gathered but action was not taken to use the information to improve care.

Blenheim Care Centres

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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 4 September 2017 and was unannounced. The inspection team consisted of an inspector, a specialist advisor and an expert by experience. The specialist advisor was a nurse. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home and spent time observing care. We spoke with the registered manager, the deputy manager the chef and two members of care staff.

We looked at five care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Inadequate

Is the service safe?

Our findings

At our inspection in August 2016 we identified that the provider had not ensured that there were sufficient numbers of suitably skilled and experienced staff employed to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. At our inspection in February 2017 we found that the provider had made some improvements but they had not been able to demonstrate compliance with the legal requirements.

At this inspection we found that the improvements in staffing levels and the reduced use of agency staff had not been maintained. The staffing levels were set on historical information. The registered manager told us that while they reviewed people's dependency the information was not used to calculate how many care hours the home needed.

There were not enough staff employed by the home to fill the staffing rota and so there had been a high use of agency staff to cover both nursing and caring roles. However, records showed that in the 10 months that the registered manager had been working at the home they had only employed six new members of staff and two of these had already left. This six included two nurses who would be starting at the home within the next few days. The registered manager told us they were still trying to recruit more nurses and care staff. However, they had told us they were trying to recruit staff at our last inspection in February 2017. Therefore the action taken following that inspection had not led to a steady and stable workforce and there were still not enough staff to provide consistent timely care.

People living at the home told us that staffing levels had been low and that there had been a lot of use of agency staff. Some of whom were very nice. However, they told us that this impacted on the care they received, with care often being delivered late in the day. One person told us that they had more pyjama days as some days they had not been supported to have a bath until 3pm or 4pm. Another person told us that the home, "Used agency staff, nearly every day." A third person told us they would get up later as they liked to wait until there was more staff to support them. They also said that some days they stayed in bed as it was more convenient. Furthermore, the registered manager told us that they would often work one or two days a week as the nurse and so this removed their focus from managing the home.

Staffing levels did not support people to access the community or to be independent and complete their own shopping. Staff told us that they chose to come in on their day off to support people to access the community or would on their day off go into the local town to purchase items for people as there was not the staffing levels to do this within their working day.

The home was also short of cleaning staff with there being only one cleaner working in the home at present. They worked as a cleaner four days a week as the fifth day they were the maintenance person. This meant that for three days a week the care staff were required to keep on top of any cleaning that needed to be done. The registered manager told us that they were in the process of employing more cleaning staff. Following the inspection the provider contacted us to say they had employed an additional cleaner.

The registered manager ensured that all the agency staff who worked in the home had received the appropriate training and had the required checks completed by the agency to ensure that they were safe to work with the vulnerable people living at the home. In addition agency staff were required to start one hour before their shift started so that they could be updated on people's needs and abilities.

This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

At our inspection in August 2016 we identified that the provider had not ensured that risk assessments had been completed to keep people safe and that medicines were consistently managed in a safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. At inspections in September and November 2016 we found that while improvements had been made the provider had not been able to demonstrate compliance with the legal requirements. Then at an inspection in February 2017 we found that the improvements had not been sustained and we could not be sure that people had received their medicines as required.

At this inspection we found risk assessments had been completed to keep people safe from the physical risks of receiving care. For example, risk assessments were in place to support people to move safely using equipment. One person told us, "I can roll over in bed to the side, then I'm helped to sit up with the aid of a walking frame and stand aid hooks, staff make sure I am steady before I stand up to transfer into my wheelchair." In addition appropriate care was in place to support people to maintain a healthy skin and to reduce the risk of them developing pressure ulcers.

However, we found that there was a bias towards health and medical conditions and less focus on people's social and emotional health. For example, some people at the home were able to access the community independently. There were no risk assessments in place around this to support staff to understand when they may need to raise a concern about people being away from the home for too long.

In addition there were some people living at the home who had refused support from staff to help them maintain a clean environment. There was a risk assessment in place around this which indicated that there were increased risks of illness due to the dirty conditions. In addition one person chose to smoke in their room and their risk assessment noted that they were putting themselves and other people living at the home at an increased fire risk. While their care plan noted that the staff should support them to maintain a healthy environment there was no actions identified on how the risks were going to be reduced.

We also saw that some people living at the home had problems with alcohol consumption. Their alcohol risk assessment indicated that when the person drank they would become confrontational with staff and the other people living at the home. There were no clear guidelines in place on how people living in the home who may be unable to protect or remove themselves from the situation could be safeguarded.

There were plans in place to support staff to take appropriate action in case of an emergency. For example, people's care files contained emergency grab sheets to be used in the event of an emergency admission to hospital. The sheets contained information about people's care needs along with any known allergies. There were also personal emergency evacuation plans in place in people's care files.

When we inspected in November 2016 we identified that people had not been protected from some environmental risks. We identified improvements in February 2017, however, at this inspection we found those improvements had not been sustained. A bathroom was out of use and was being used to store equipment. However, the registered manager was unable to secure the room to prevent people accessing it

and hurting themselves on the equipment. This was because the door's carpet gripper was twisted and prevented the door from fully closing. A second bathroom was not being used and the drain hole was open and a hazard to people. This bathroom was again used to store equipment. However, it was not locked to prevent people going into the bathroom and hurting themselves. We saw that there were some trip hazards in the home which needed attention. For example, the carpet gripper between two different carpets was incomplete and this meant there was a risk of people getting their feet caught in the unsecured carpet and tripping.

The provider had improved their management of medicines. However, one person had not taken their medicines with them when they left the home to go out into the community. The person tended to go out one day a week. We discussed this with the deputy manager who told us that the person never took their medicines with them. There was no guidance in their care plan about how this person should be supported to take their medicines in line with their prescription when out in the community. In addition this person's medicines came in a monitored dosage system and so each medicine was allocated a date and time it should be taken. We saw that where they had missed a dose staff had given this to them at a different time. This meant that the Medicine Administration Records (MARS) sheets did not correspond to the medicines in the dosage system.

This was a continued breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were supported to take their medicines. One person told us they had, "Loads of tablets, the nurse, says have a drink and stands there while I take them and I always take them." In addition the person told us they were able to have their medicines at a time which suited them. They described how they would use the call bell to alert staff that they were ready to go to sleep and needed their tablets.

Staff in the home looked after people's medicines for them and administered them. We saw that there were systems in place to manage people's medicines. For example, MAR's had a top sheet which included a photograph to help staff identify if they were administering medicines to the correct person. In addition people's preferred method of taking medicines was listed along with any allergies. The sheet also noted any guidance from the person's doctor. For example, there was advice that one person should not be offered certain medicines when they were intoxicated. Records showed that stock levels were monitored and the medicine available matched the identified stock levels.

Where people were prescribed medicines to be taken as required there was clear guidance in place to support staff to offer this medicine in a consistent way. The guidance also included information on the dose to be offered, the frequency that it should be offered and the maximum number of times it should be offered in a 24 hour period. For some medicines the maximum number of times it may be administered in a month was recorded before the person needed reviewing by a doctor. In addition it was recorded if medicine would interact with other medicine the person was taking.

We observed the deputy manager and saw that they administered medicines to people safely and in line with best practice guidance. They ensured that people had taken their medicines before recording it in their MAR. We saw that where people asked about their medicine the deputy manager knew what each table had been prescribed for and was able to discuss them with the person. The morning medicines round had been completed by the registered manager by 9:30am.

The provider had systems in place to ensure they checked if staff had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people

had completed application forms and the registered manager had completed structured interviews. The disclosure and baring checks which identify if people have any criminal convictions had been completed to ensure that staff were safe to work with people who live at the home.

When we inspected in August 2016 we had identified concerns around cleanliness. At following inspections we noted an improvement in the cleanliness. At this inspection we found that the improvements had been sustained, but that more staff were needed to ensure standards continued to be met. People living at the home told us that the home could be kept cleaner as they did not always a have a member of the cleaning staff on duty.

There was currently a cleaner working at the home four days a week. The registered manager told us that they were currently looking to employ another cleaner. At present there was no set cleaning schedule in place to ensure that all the required cleaning was completed in line with current best practice. Following the inspection the registered manager submitted cleaning schedules which showed that on the day of the inspection there no cleaning occurred in the home. We discussed the cleaning with the registered manager who confirmed that a new policy had been put in place by the provider with an associated cleaning schedule and they were due to implement this within the home when they had employed a second cleaner.

All the staff we spoke with confirmed that they had received training in infection control and could tell us how they worked to reduce the risk of infection. For example, the cleaner was able to tell us how they used different coloured cloths in each area to reduce the risk of cross contamination. The care staff were able to tell us how they worked to reduce the risk of cross infection when providing personal care to people. This included the use of personal protective equipment such as aprons and gloves alongside washing hands and use of antibacterial hand gel. People confirmed that staff always used protective equipment.

There were good infection control processes in place in the laundry. For example, the use of red bags for contaminated washing which dissolved in the wash to keep the handling of soiled linens to a minimum.

Infection control processes were completed in the kitchen, for example, we saw that all the food in the fridge was covered and labelled with the date it was made. Fridge temperatures were monitored as well as the temperature of the food before it was served to ensure that it was hot enough to kill any bacteria. The kitchen had been inspected by the local authority and was awarded the highest rating to show that systems were in place to keep the kitchen clean.

An infection control audit had been completed and concerns had been identified. Following the inspection the provider sent to us an infection control action plan. However, not all actions had been completed and there were no dates set for actions to be completed by. We therefore had no confidence that actions would be taken in a timely fashion. A member of staff attended the local authority infection control meetings to ensure they stayed up to date with the latest best practice.

People told us that they were happy living at the home and felt safe there. Staff we spoke with had received training in how to keep people safe from abuse and how to recognise the different types of abuse. In addition they were clear on the action they would take if they noticed any concerns or if a person living at the home raised a concern with them. Staff knew how to raise concerns both within the home environment and with external agencies if needed.

The registered manager had responded when they identified that a member of staff was emotionally abusing a person who lived at the home. When the first incident was reported the member of staff was spoken with and increased supervisions were put in place to provide guidance and support for the member

of staff. However, when a second concern was raised the registered manager dismissed the member of staff to safeguarding the people living at the home.

Several people raised concerns about their ability to keep their valuables safe. One person told us they had asked about a safe and was told that they did not need one as they kept their money in their bedroom. Another person told us how they kept sentimental jewellery close to them as they did not have access to a safe. Following the inspection the provider informed us that all people's valuables were kept in the home safe.

Inadequate

Is the service effective?

Our findings

The home was registered to provide care for 80 people and the service was provided across two buildings. However, one of these buildings was empty and the registered manager told us that it had recently been vandalised and was no longer fit to be occupied. In addition three of the 10 flats were derelict and not habitable. The registered manager told us that these were being refurbished but was unable to tell us what was planned or give any timescales for when they would be completed.

The bedrooms did not support people's dignity. For example, each bedroom had a toilet and washbasin, however, these were not in an en-suite but were in the bedroom themselves. Privacy curtains had been provided but they did not give people much room. For example, when people sat on the toilet the privacy curtain would touch their knees. In addition we saw that rooms were not allocated to support people's needs. One person had a steel beam for a hoist approximately four foot above their bed. The beam was intrusive and ran the whole length of the room. When we discussed this with the registered manager they told us that the person in this room did not need to use a hoist at all. This showed a lack of person centred care, as despite the large number of vacancies the person was still accommodated in a room that was not suitable for their needs.

The home was in poor condition in regard to both the maintenance and fabric of the building. The colours were dark and depressing and with poor physical lighting. Around the home the quality of the décor did not support people's well-being, with chipped architrave and skirting boards and many areas needed redecorating. In addition the decoration did not support people to find their way around the home and there was a lack of signage to support people's independence.

The outside area was also not well maintained. For example, a patio area just off the activity room was left untidy with a ride on lawn mower left to sit on the patio with four tyres piled up to one side. The area had not been maintained and weeds had grown up between the paving slabs making the area inaccessible for people using mobility aids or wheelchairs. Pots used for flowers were overgrown with weeds and this was not a pleasant area in which to spend time. To the back of the home the garden path was not accessible for people in wheelchairs as the shrubs had grown over the path. In addition they were blocking the light to some of the bedrooms. The registered manager told us that they had plans in place for these to be cut in a few days' time. A person living at the home told us that Blenheim Care Centre would benefit from having a gardener.

Following an earlier inspection we had raised concerns around the security of the home and in response to this the provider had installed a fence around some of the home. However, the fence had been installed close to the home instead of at the boundaries to the garden. This caused the area to feel enclosed and cut off. One person told us that the new fence blocked the views of the countryside. We raised this with the registered manager who told us that this had been the cheapest option and that if they had more people living at the home then they may have enough money to get the fence moved.

Several of the bathrooms were out of order. The registered manager showed us one bathroom which had a

new floor. They told us that this was going to be turned into a wet room. However, there was no drainage in the floor. In addition the registered manager was unable to give us a timeframe for when the bathroom would become operational again. We saw another bathroom had a new floor but again there were no definite plans for when it would become operational again. Following the inspection the provider wrote to us and told us the bathrooms were under refurbishment and temporarily out of order. They said they had assessed that one bathroom and two shower rooms were sufficient on a short term basis. However, the provider had not indicated if this work had been completed or the expected time scales when the facilities will be available for people to use.

The registered manager had also not ensured that the fire escapes were well maintained. For example, one fire escape had loose carpeting on most of the steps and the area at the bottom of the stairs was used to store a large gas stove which had been removed from the other building. When we raised this as a concern with the registered manager they were unaware that the stove had been stored there.

The smoking shelter was not adequate. It had a single chair in it and was uninviting. It did not provide enough shelter for people in wheelchairs to use. During the day we saw that several people in wheelchairs used the smoking area but none were able to access the shelter.

We saw that the lighting was not adequate in the corridor which people used to access their flats. The area was dark and unwelcoming. In addition the lights in the lift were not all working making the lift dark and unfriendly.

Maintenance was not always completed. For example, the activities room had a door leading to the store room, we saw that there was a notice on the door stating that the door was not to be fully shut as the lock was broken. In addition we saw that a bathroom was out of order as the light bulb needed replacing. We saw that this had been identified on the maintenance plan in June 2017 but had not been replaced. The maintenance person worked one day a week and had a list of jobs to be completed. However, records showed that these were about the general upkeep of the home and did not support the refurbishment that was required. The upstairs sluice room floor was dirty and the flooring was peeling away from the wall and creating an infection control risk.

We saw that one flat was at a stage where it was becoming unsafe for the people who lived there. The flooring in the hallway has lifted and cracked and this made it hard for the person who used a wheelchair to enter their flat. It was clear that these people had collected too many objects to fit into the flat and that this was becoming a hazard to their health making it impossible for them to clean properly. In addition despite there being a no smoking inside policy one person chose to smoke in the flat making the atmosphere unhealthy and introducing a fire risk which would put themselves and others living in the home at risk.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations Premises and equipment.

At our inspection in August 2016 we identified that the provider had not ensured that people's capacity to make decisions had been suitably assessed and that all of their legal rights would be maintained, In addition they had not ensured that the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) had been correctly implemented. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent. At our inspection in February 2017 we found that the provider had not been able to demonstrate compliance with the legal requirements.

We still identified concerns around people's consent at this inspection. 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 home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Four people living at the home had a DoLS in place to restrict their liberty as they were unable to safely access the community unsupported.

Staff told us and records showed that they had received training in the MCA. They were able to tell us how if people had capacity they had to respect their decision. They were also aware that where people lacked capacity then a decision would need to be made in their best interest.

However, we did not see the MCA applied correctly in care plans. For example, in one person's care plan there was a mental capacity assessment check list. This stated that the outcome for all assessments was that the person lacked capacity to make their own decisions. There was no record that any assessments had actually been completed for this person. In addition we saw that consent to care forms remained unsigned in people's care plans.

The registered manager's knowledge of the MCA did not fully support the people living at the home. For example, some of the people living at the home were alcohol dependant. There was no record of how their consumption of alcohol and need for consumption of alcohol impacted on their ability to make decisions. The registered manager told us and records showed that they believed people had the ability to make decisions when sober and drunk.

We saw that some people had a do not resuscitate notice (DNACPR) in their care plans. However, we saw that these had not always been appropriately completed and so the forms were invalid. Therefore health care professionals would ignore them and attempt to resuscitate the person in an emergency. This meant the person's wishes and those of people making the decision not to resuscitate in their best interest would not be respected.

This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations Need for consent.

At our inspection in August 2016 we identified concerns with the level of knowledge and skills of the staff in the home and the support they received to carry out their roles. At our inspection in February 2017 we found that the provider had not been able to demonstrate compliance with the legal requirements.

At this inspection we found supervision had not always happened in line with the provider's policy of at least six supervisions a year. Records showed that eight months into the current year the majority of staff had only received two supervisions. One member of staff we spoke with told us that they had not had a one to one with a senior member of staff in the time they had worked at the home. However, they did say if they had any concerns or training needs they would discuss them with the registered manager.

This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations Staffing.

The registered manager had supported staff to complete e-learning courses in all of the key areas that staff needed to provide safe care and support. Staff told us that the registered manager had made a difference and that they were now all up to date with their training. They told us that if there was something that they didn't know they could ask the registered manager for advice and support.

The registered manager had developed a set induction program for new staff which consisted of some e-learning and then shadowing an experienced member of staff. However, they told us that no one currently working at the home had undergone this new induction process as it had been recently introduced. All staff were in the process of completing the care certificate although no competencies had been observed or checked at the time of our inspection. The care certificate is a set of national standard which support staff to provide safe care.

People were complementary about the food provided. One person told us they, "Loved the food." The chef had developed an eight week menu to ensure that people did not get bored with having the same food. There were two options offered for the main meal each day and people were also able to request other foods such as a jacket potato or an omelette if they did not want the set options. People were able to choose what they wanted for breakfast and tea each day and the chef would prepare what they chose. The main kitchen was locked between 6pm and 7:30am. However, there was a residents' kitchen where people living at the home and staff could make hot drinks and the kitchen staff left sandwiches each night for supper. In addition snacks such as biscuits, crisps and fresh fruit were also available. If people chose to they could also order takeaway food to be delivered.

Records showed that peoples' ability to maintain a healthy weight was assessed and monitored. These assessments were regularly reviewed to ensure they reflected people's current needs. Where needed people had been referred to a healthcare professional for guidance and support. Where people needed support to eat we saw that this was given in a way which respected people's dignity and engaged them with the food.

Where staff had concerns about people's ability to eat safely we saw that they had been appropriately referred to a specialist to be assessed. Where needed a modified diet was provided to ensure that people could eat safely. For example, we saw some people required their food to be of a mashable consistency.

People were supported to access hot and cold drinks on a regular basis. People had access to cold drinks throughout the day and hot drinks were available on request. People who had the ability were able to make their own hot drinks in the residents' kitchen.

People told us that they had been supported to access healthcare professionals on a regular basis. For example, one person had been escorted to the hospital to attend an appointment. However, other people had been left to be independent when accessing healthcare. One person told us, "Perhaps it would help if someone went with me to the appointment." People had been supported to access a GP when needed and were confident that the staff would arrange support from a doctor if they were not well.

Requires Improvement

Is the service caring?

Our findings

At our inspection in August 2016 we identified that people's dignity was not fully protected. When we inspected in February 2017 we found that the action taken had still not fully supported people's dignity.

At this inspection we still identified concerns around people's privacy and dignity. There were mixed opinions about the registered manager's ability to maintain confidentiality. One person told us that if they spoke with the registered manager regarding any concerns, that it would remain confidential. The person told us, "Once said it stops there." However, before our visit one person had raised concerns with us about the registered manager not respecting their right to privacy. They raised this with us again when we visited. Their concern was that the registered manager had started to discuss their financial status with them in the corridor where other people living at the home could hear. This had distressed the person. In addition, they felt that the registered manager and the provider did not respect their privacy and would walk into their room without knocking or waiting for permission to enter.

Records showed that the last residents' meeting had been aborted half way through as the person's frustrations had affected their behaviour. There was no information available in their care plan on how this person could be assisted to voice their concerns without coming into conflict with the registered manager.

Another person told us how their felt their dignity had been compromised when staff had not brought them any air freshener for their bedroom. This person was nursed in bed and needed support with their continence and wanted the air freshener to keep their room pleasant for themselves and any visitors they may have. They told us, "I've waited a few days to get this and this is normal to wait."

People told us that the staff respected their dignity when providing personal care. One person told us, "Staff ask, do you want me to do X – they always ask, don't just do it and staff are respectful with personal care in private areas." We saw that staff knocked on people's doors and waited for permission before entering. Staff were able to tell us how they supported people's privacy and dignity when providing care by ensuring doors and curtains were closed and by asking for their consent before providing any care.

One person told us, "The staff are good." Throughout the day we saw that staff had a caring and gentle way of interacting with people living at the home. For example, one member of staff spent time admiring a plastic brick model a person had made. We also saw that staff offered people physical comfort such as a hug when needed. In addition a member of staff told us how they would run errands for people or support them to access the community on their non working days.

People were offered a choice of food and there was a menu on the wall. However, this was in small writing and may not be accessible for everyone. In addition there was a picture menu available but again this was on the wall and people may not see it. There were no menus on the tables.

People told us that they were able to make choices about their everyday lives. For example, what clothes they chose to wear and where they spend their time. However, at times the staffing levels impacted on

people's ability to choose. One person told us, "Somebody gets me up, I would rather get up later." When asked about going to bed the person said, "I go when I want."

One person we spoke with voiced their frustrations about still living at Blenheim Care Centre. They told us, "I want my own flat, place to live." Another person told us they also wanted to move out of the home and a third person's records showed that they wanted to return to the country of their birth. We saw that these choices had been made prior to our last inspection. However, there had been no positive outcomes for these people and so they were still living somewhere they did not want to be. We discussed this with the registered manager who explained that issues with people's financial situations had impeded the process.

People told us how they were supported to have equipment which increased their independence. One person described how staff had supported their independence with eating by providing them with a feeding strap which held the spoon in place, which enabled them to maintain independence which they valued.

There was a noticeboard outside of the registered manager's office where the minutes of the last residents' meeting were pinned to the board. The font size for the writing was small and the information was presented at a height which made it difficult to read from a wheelchair. There were no other formats used to convey the minutes. One item in the minutes stated that notices were too high up on the noticeboards to easily read or understand. However, no action had been taken to make it easier for people in wheelchairs to access the information.

Important information about the home had been translated into the first language of one person in the home to ensure that it was accessible to them.

No one using the home was supported by an independent advocate. However, the registered manager had ensured that information on how to get an advocate was available for people. One person told us, "I've seen and read leaflets and didn't feel that I needed one."

Requires Improvement

Is the service responsive?

Our findings

When we inspected in August 2016 we found shortfalls in care planning had not supported people's needs. At our inspection in February 2017 we found that while care plans had been reviewed they had not been consistently updated to reflect people's care needs.

At this inspection we found that care plans had been regularly reviewed and updated and reflected people's needs around their health and physical care. However, information on how to support people's emotional needs had not been recorded.

People told us that they had been involved or offered the opportunity to be involved in planning their care. One person told us they were aware of what a care plan was and knew that they had one. However, they were clear that they had not wanted to contribute to it. Another person told us that they had been involved in the writing of their care plan and had been through it to see if they wanted to change anything. The provider had translated one person's care plan into their first language so that they were able to understand the information in their care plan and contribute to its development.

However, people told us that at times care did not always support their needs. For example, one person told us, "Shower, I haven't had one for ages, I'm too big for shower chair, but I like to have a shower." This did not support equality for this person and the provider had failed to provide the correct equipment which would support them to shower.

Another person told us that their electric wheelchair was uncomfortable and too heavy for them to utilise it fully. They said they would like a new wheelchair as the current one meant that they spent significant periods of time in their bedroom as the wheelchair restricted their ability to move around the home.

We saw that people's conditions were not being fully investigated and supported. Two people chose to live in a cluttered unclean environment which was not good for their health. They refused support from the staff to help them clean their home. There were risk assessments in place around this and a care plan around maintaining a safe environment. However, we saw that staff had been unable to do this due to the amount of things the people had collected. There was no care plan in place on how they were going to support people to become less attached to their collection and more accepting of support from the staff.

Several people living at the home misused alcohol. We looked at the care plan for one person who misused alcohol and could see that they had indicated that they did not want to stop drinking. The registered manager had completed a risk assessment about this behaviour and had identified a number of concerns. These included that the alcohol may react with medicines the person needed to take and that alcohol made the person confrontational. The registered manager described the provider's alcohol policy to us and we saw that both of these behaviours should have meant that there was a restriction on the person drinking alcohol on the premises. No restriction on the consumption of alcohol on the premises was in place. Therefore the provider's policies were not being adhered to.

There was no care plan in place around the management of the misuse of alcohol. The registered manager told us that as the person did not want to stop drinking there was nothing the staff could do to help them. There was no care plan in place about what actions such as encouraging activities and improving the general wellbeing of the person may have on their wish to misuse alcohol. This person told us they were not always happy at the home and felt like they were wasting away their life. They spoke about wanting support to visit places and suggested a local seaside town. When asked about the activities on offer in the home they told us, "I don't join in with the activities, they are too basic and I don't see the point." This person was able to access the community independently but told us, "No, not part of the community, stuck in the middle of nowhere, I don't use buses."

Their activity care plan did not support them to engage with the local community or include information about what they may like to try or activities which may improve their wellbeing. The person told us that they liked gardening but there was no encouragement to take part in maintaining the home's gardens.

There was no dedicated activities staff but the registered manager told us that activities were provided by the staff on shift between 2pm and 4pm. Staff confirmed this and said that they would look on the notice board to see what activities had been planned. However, staff told us that while everyone was asked to join activities a lot of people chose not to. When people chose not to join in activities staff told us they tried to spend time with them on an individual basis.

The activities records showed that activities such as colouring, bingo and listening to music had taken place. However, they also showed that some people chose not to join in with the activities. One person told us that they did not bother with activities as they were childish and consisted of pass the parcel and colouring. They told us that they used to have some more interesting activities but that this had stopped when the current registered manager took over. For example, they had previously held a Macmillan coffee morning but this had not been scheduled this year. They said that every time they made a suggestion they got, "Knocked back."

People told us that they spent time watching television. One person told us that they were bored at times. Another person who needed support to access the community told us that this did not happen as often as they would like due to staffing levels. People told us that they had not been asked about their hobbies or if there was a hobby they would like to engage with. People who were unable to access the community independently were not supported to shop for themselves as an activity or as a way to increase their independence.

There was information on how to raise a complaint on display in the entrance hall. People told us that they were happy to raise complaints and would raise them with the staff or the registered manager.

One person we spoke with told us that they had put in a written complaint two months ago about the doors banging in the middle of the night. They told us that the provider and registered manager had failed to respond to this complaint. We raised this with the registered manager who told us that they had not been aware that a complaint had been submitted and would look into the matter.

Inadequate

Is the service well-led?

Our findings

At our inspection in August 2016 we identified that the provider had not ensured that quality assurance systems were reliably managed to ensure that they identified and resolved shortfalls in the care provided for people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. At our inspection in February 2017 we found that the provider had not been able to demonstrate compliance with the legal requirements.

We looked at the information we held on our system about the provider. The sole director of the provider was also the only person who had significant control over the company. Records showed that they were the sole director and person with significant control over two other provider's registered with the CQC. Each provider had one location registered. We saw that the director had been unable to ensure compliance in one location and that improvements were needed in the second location to ensure that people received care which consistently met their needs. This showed that the provider did not have effective systems in place to support the homes and registered managers to provide high quality care to people.

At this inspection there was some confusion over the care provided to people living in the flats. The registered manager explained to us that the flats were for independent living and the fees paid for these flats did not cover any care or food but this was provided for the people in the flats for free. They told us people living in the flats were responsible for replacing the soft furnishing such as carpets and curtains when needed. There was no documentation to show that this was what people living in the flats had agreed to. Following the inspection we contacted the local authority who confirmed that these people were receiving a full package of residential care, which included care and food and ensuring that the fixtures and fittings were in good order.

We saw that this had caused confusion for people as when they needed new carpets they had understood that the provider would replace them and had then been told it was their responsibility. We raised this as a concern with the local authority who told us that the people living in the flats had been funded to receive care the same as anyone else living in the care home. All of the people living in the flats had a care plan in place and received regular support by a member of staff who was allocated to support all the people in the flats.

In addition we found that there was a lack of clarity from the provider about what equipment they needed to provide for a person living in the home. The maintenance plan showed that the provider had replaced the flooring in several of the bedrooms. However, one person whose bedroom was identified as needing new flooring and furniture had been asked to pay for this equipment themselves. The registered manager had also identified that they required an alert mat to notify staff when they started to move around their room as they were at high risk of falls. They had also been required to pay for this piece or equipment. Therefore the provider had not accepted their responsibility to provide the appropriate furnishing and equipment to meet this person's needs.

There was a suite of audits in place. However, we found that they did not fully identity the concerns we

highlighted at our visit. For example, the audit completed on 27 August 2017, a week before our inspection, showed that all floor covering was of an acceptable standard. We found a number of areas where the flooring required attention. In addition where audits had identified concerns clear action plans with timescales had not been put in place to ensure appropriate action was taken.

There had been some progress in involving people in improving the quality of the care provided. A Residents' meeting had been held in July 2017 and the registered manager confirmed that these would be held every three months going forwards. The registered manager used the meeting to keep everyone up to date with the outcome of the fire safety audit and discussed the changes that they were going to make. People raised concerns around the staffing and that they kept seeing so many new staff they said they found it disconcerting. A number of people raised concerns about the outside and asked if could be tidied up. People also commented about being supported to access the community more and to go shopping. However, we found no action had been taken to resolve any of the concerns raised. During our inspection people still raised concerns about the standard of activities and the state of the outside space.

In addition we saw that some people raised concerns that at weekends when the area was busy some people parked on the neighbouring car park blocking the pathway which was the emergency escape route for home. The registered manager did not identify any actions they could take to improve this situation. They did suggest that people living in the home were able to go and ask people not to park there. This may put people at risk of being in confrontational situations with members of the public.

The registered manager had also asked people to complete a survey about their experiences of living at the home. Records showed that the registered manager had taken action to resolve some individual concerns. For example, one person had raised concerns about not having a regular shave and the registered manager raised this with staff. However, no action plan had been put in place to improve the overall quality of care in the areas which scored low in the survey.

The maintenance plan showed that most of the everyday jobs needed to keep the home running were attended to. For example, soap dispensers were replaced and the fencing was fixed. In addition the maintenance plan shows that some carpets were replaced. However, there was no overall refurbishment plan of how the environment was going to be brought to an acceptable standard.

We asked the registered manager to tell us when the latest safety checks had been completed around the home. They told us that the last gas safely check had been completed in 2015. However, following the inspection the provider sent paperwork to show that the gas check had been completed on 9 August 2016. remedial work was identified as needed on the documentation but no evidence was submitted to show that this had been completed. The current guidance issued by the Health and Safety Executive is that Gas appliances, and associated pipework, flues and ventilation, should be checked for safety at least once a year by Gas Safe registered engineers.

This was a continuing Breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014 Good Governance.

Staff told us that the registered manager was supportive. One person said, "[The registered manager] is good, they won't tolerate joking and wants the job doing and will tell you if you do something wrong. If there is a problem you can knock on their door and they will listen and we can decide what to do." Another person said, "I am happy to raise concerns and even though they can get stressed and be unapproachable I'd still go to them and 99 times out of 100 they will do something."

The accident and incidents book showed a regular monthly audit, which considered patterns and highlighted regular incidents for further investigation, which is good practice.

The provider had fulfilled their responsibilities to notify us about the events that put people at risk of harm and injury. We had also required the provider to provide monthly audits about people's risk assessments and medicines and we had received these each month. The provider had also displayed in the entrance hall to the home the rating we had awarded the home at our last inspection in line with the regulations.