Bluewater Care Homes Limited

Bluewater Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

Bluewater Nursing Home is a residential care home providing personal care to 21 people aged 65 and over at the time of the inspection. Some people were living with dementia. The service can support up to 60 people. Although it is called a 'nursing home', it is not registered to provide nursing care. The home is based over 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 ground and first floors were in use at the time of the inspection.

People's experience of using this service and what we found:
We carried out this inspection to look at specific risks we had been told were a concern. This included risks associated with choking, risks associated with safety equipment and risks associated with a lack of personal care. We found ongoing concerns about the risks associated with choking for one person. Although, we did note that some action had been taken to address wider concerns about the risks of choking for other people following our last inspection. We found ongoing risks associated with the use of safety equipment, which included a failure of staff to follow care plans.

Other risks were identified at the time of this inspection, including risks of scalding from a freshly boiled kettle being left unattended, fire extinguishers not being secured, and the sluice room door being left open on a number of occasions. Items within the sluice room were known to be a risk to one person if they were to consume them, which was a known risk. We were also concerned that one person was being cared for in bed, but it was not evident that a multidisciplinary assessment had taken place to confirm this was appropriate for this person.

We found concerns relating to people's hygiene needs not being met as some people had unclear fingernails.

We asked the provider and manager what action they had taken to address our concerns and they told us of some action taken, which would reduce any immediate risk to people. However, our findings at this inspection demonstrated an ongoing concern about the culture and oversight in the service. Based on our feedback as well as previous inspection findings, we would have expected the provider to have implemented a clear systematic approach to addressing the culture in the service. Furthermore, we would expect checks on staff actions and competence, which would aim to ensure that people were not placed at risk. The provider and manager did not advise us of this as part of their response to our request. Due to finding ongoing concerns of a similar nature, we were not assured the registered person had taken the required action. We asked the provider to send us assurances and are considering our regulatory response.

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

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

Why we inspected
The inspection was prompted due to serious concerns we had received about the safety of people living in the home. This included risks associated with choking, the use of safety equipment and a lack of personal care. We undertook this targeted inspection to inspect and examine those risks. The overall rating for the service has not changed following this targeted inspection and remains inadequate and in special measures.

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

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

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

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
At the time of this inspection the service was receiving input and support from a number of health and social care professionals to keep people safe. We will continue to liaise with the provider and all relevant agencies already involved in supporting the service. This will inform our ongoing monitoring of the service until we return to visit. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

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

Bluewater Nursing Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to inspect and examine concerns we had received regarding people's safety. The overall rating for the service has not changed following this targeted inspection and remains inadequate and in special measures.

Inspection team
The inspection team consisted of two inspectors. CQC were accompanied by two representatives from the Local Authority.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager was working as the acting manager at the time of this inspection visit. We refer to this person as the manager throughout the report.

Notice of inspection
This inspection was unannounced.

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

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

records for two people.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with four members of staff, the director of the company, the manager and the head of care.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

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

Assessing risk, safety monitoring and management;

● At the last three inspections we found the provider had failed to ensure the safe care and treatment of people. Risks to people were not always assessed and where assessments were in place, we were not assured staff understood or adhered to these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to this inspection we received concerns about the safety of people using the service. These concerns related to risks associated with choking, risks associated with safety equipment and risks associated with a lack of personal care.

● At previous inspections we were concerned about the risks of people choking. Following the last inspection, we asked the manager and provider to take immediate action to address the risks. They told us they had implemented clear signage in the kitchen and in people's rooms who were at risk, provided an information sheet for staff which highlighted the risks and had also undertaken training with staff.

● At this inspection we found signage was in place and on display in people's rooms and in the kitchen. Although we noted this did not always match what was in some people's care plans. An information sheet was available for staff to carry with them to ensure they could safely meet people's needs. However, we spoke with four staff members, all of them told us they did not have a copy of this on their person. One said, 'I don't need it, I have it in my head'. Two of three staff we asked, told us they hadn't received any recent training in this area. One staff member had never received this training and the other said, they had last done this training at the end of 2020. This meant we were not assured that the actions the manager and director told us had been taken, were effective and completed in full.

● Prior to this inspection, the local authority raised concerns with us that during an observation visit, they had seen food of an unsafe texture, being provided to two people who were at risk of choking. At this inspection, we observed the lunch meal was prepared to the appropriate consistency for people and those who required support were given this.

● Although we observed this, we remained concerned that records for two people indicated that at times they were provided with food items that national guidance recommends should be avoided, For example, green beans, gammon and biscuits.

● We asked two staff how they would prepare gammon for a person on a soft and bite sized diet and they said this would not be given because it is difficult to chew. However, one person's records recorded they had been given this. Therefore, we could not be assured people were always receiving the correct texture of food, in line with their assessed needs.

● When we asked a third member of staff how they ensured biscuits were prepared to a soft texture, as we

saw records which confirmed these were regularly provided. The way in which they described this process would have ensured they were the appropriate texture.

● At the last inspection we raised concerns with the manager about a person who may be at risk. This was because staff had told us that sweets family members bought in for them, placed them at risk. Staff said they removed these when family members left. We asked the manager to take action about this to ensure the person was safe. Whilst they confirmed they had spoken to the person's family about this, the manager did not confirm they had discussed with staff, the need for them to be aware, remove items at risk and have gentle discussions about the changing needs of people. At this inspection we found sweets in an unlocked draw in this person room, which could place them at risk. We were concerned by the staff response when we discussed this with them. When asked what system they had in place to check food items in people's rooms, especially after visits they said, 'If we notice, we will remove'. This was concerning as it meant they had no system in place to ensure the safety of the person and staff would only remove unsafe food items if they noticed. We attempted to discuss this with the director and manager, however the director appeared to either lack an understanding of the risks this posed or was unwilling to acknowledge the risks. They stated the person was not at risk because they could not access the food items. We were required to highlight that having the items of risk accessible in a person's room, left them vulnerable to someone giving them to the person.

● At the previous two inspections we had identified concerns regarding the use of safety equipment as we had found that when people's care plans stated this was required, the equipment wasn't being used.

● Prior to this inspection we had been informed of a potential risk for one person because staff had left the footplates on their wheelchair down. This person was a high risk of falls and records showed they had attempted to stand from the wheelchair. The risk of leaving the footplates down, was that they would cause of potential trip hazard as well as an entrapment risk. External professionals had advised that staff should remove the footplates or make sure they were moved out of the way, when the person was stationary in their wheelchair. The person's care records reflected this. However, during our visit we observed this was not done and when the person was seated in their wheelchair in a stationary position at the dining table, the footplates remained down. This placed them at continued risk.

● During a local authority visit to a person they told us that they had observed no sensor alarm or crash mat in place despite the care stating this was required. At this inspection a member of staff told us these pieces of equipment should be in place and confirmed. However, we did not observe these were in place and the member of staff confirmed they were not in place during our visit. The manager told us the person was now cared for in bed with bed rails and no longer needed this equipment. However, it was unclear who had made the decision this person was to remain in bed and an assessment suggested they had a good sitting balance so it was not apparent why they could not sit in a chair. We could not see from the records that alternatives had been considered or a multidisciplinary approach had been implemented, to assess the person's needs. We were concerned that this person was at risk of unnecessary restrictions.

● During our site visit, the local authority representatives told us they had informed staff three times to ensure the sluice room door was shut. We had not been present on these occasions. We did, however see on two occasions that the door to the sluice was left open and it contained multiple bottles of hand sanitiser. The manager confirmed that one person had previously attempted to drink hand sanitiser. This person was very agitated, wandering throughout the floor and attempting to get into numerous rooms at the times we found the doors open. We could not be assured that this room was consistently locked in order to mitigate the known risks. The director told us they would look at the door and make sure it would shut properly after people left the room.

The failure to ensure an appropriate and effective assessment and mitigation of risks was an ongoing breach of regulation 12 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

● The local authority who were present at the time of our inspection, also fed back to the manager and director about observations of concern they had seen but we had not witnessed. This included a freshly boiled kettle containing hot water, being left on the side, unattended and despite signage being in place to tell staff not to leave this kettle out. This was at a time when a person was very agitated, wandering throughout the floor and attempting to grab various items. They also fed back that two fire extinguishers in the same area were not secured to the wall and a person who was clearly visibly agitated had picked these up. This was a person who the manager told us had hit a member of staff in the morning, because they were agitated during personal care. The head of care said this person had pulled the extinguishers off the wall. The manager said they would discuss other options with the fire service.
● We had been made aware by local authority representative that on their visits, people had observed to be left in their own faeces and urine which had dried. At this inspection visit we did not observe this and the local authority representatives who accompanied CQC on this visit confirmed they did also not observe this. However, we did note that some people who were living in the home, had unclean fingernails. These had a brown substance under their nails, and it indicated they had not been appropriately supported with this. We shared this with the manager and director. The director stated they did not agree with our observation and sent a member of staff to take pictures. The member of staff returned with photos on their personal phone, showed these to the director and said, 'There are three' and stated the names of those people. This member of staff then showed the photos to one of the inspectors. The photos showed these people's nails remained uncleaned. In addition, the local authority representatives showed us during our visit, an incontinence pad that was full of faeces, that had been left on a person chest of drawers, open. They had been required to tell staff to remove this. We could not be assured that people's personal care needs were being met or their dignity respected at all times.

● After the inspection we shared these concerns in writing with the provider and manager. We asked them what action they would take to address the significant concerns we had found. They confirmed they had taken some action to reduce any immediate risk of harm to people but did not provide any assurances about their oversight of the service.
● Our findings at this inspection demonstrated an ongoing concern about the culture and oversight in the service. Based on the last three inspections carried out at this service, we would have expected the provider to have implemented a clear systematic approach to addressing the culture and checking staff actions and competence, which would aim to ensure that people were not placed at continued risk. Due to finding ongoing concerns of a similar nature, we were not confident the registered person had done this. We asked the provider to send us assurances and are considering our regulatory response.