Bluewater Care Homes Limited

Bluewater Care Home

Inspection report

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Date of inspection visit:
25 March 2021
08 April 2021
15 April 2021

Date of publication:
19 October 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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 27 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 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 floor 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

People did not receive a service that ensured they were safe and received the care they required.

The recruitment of staff did not always ensure people were protected against the risks of unsuitable staff. The registered person was unable to demonstrate safe recruitment processes were followed and that appropriate pre employment checks had been completed for all staff before they were allowed to work with people. People who were able to tell us said staff were available when they needed them however, on occasions we observed staff were not always present to be able to provide prompt support to people. We have made a recommendation about this.

Appropriate policies were in place regarding safeguarding and staff had access to training however, they were not always able to describe safeguarding and explain how they could report concerns externally. We have made a recommendation about this. Whilst training was available to staff, due to the concerns we found at this inspection we were not assured the registered person had ensured staff were competent to perform their role.

Staff were not always aware of the risks associated with people's needs. People's care plans and risk assessments did not always contain the information needed to guide staff how to meet their needs and keep them safe. Where risks were known, people did not receive the care and support they required to reduce these risks. Examples of this included records which documented people did not receive the correct food types to manage risks of choking and people were not supported to change position and reduce the risks of developing pressure sores. Where people were at risk of falls, equipment specified in the care plans was not used and when people fell, the appropriate checks did not take place following these falls.

The management of medicines was not safe. The amount of stock of medicines in the service did not match the records, meaning we were not confident people received their medicines as they were prescribed. Where people were prescribed creams to help maintain good skin integrity, these were not always applied. Information to guide staff about the use of 'as required' medicines was not available to guide staff appropriately. The management of infection, prevention and control was not always effective and did not

keep people safe. However, the provider took and number of actions throughout our inspection to address the infection control concerns. People's nutrition and hydration needs were not always met, and staff did not escalate concerns about people's health needs promptly. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests.

Staff in leadership roles did not always promote the delivery of high quality person centred care or act in an open and transparent way. Governance processes were ineffective. When things went wrong in the service, we were not assured these were incidents were analysed effectively, and lessons were learned and applied to reduce the risks to people and ensure their safety. The provider has demonstrated a consistent failure to make and sustain improvements. They have demonstrated a consistent failure to meet the requirements of the regulations.

Feedback from people, relatives and staff was mostly positive about the management of the service. Although we observed some negative interactions, we did on occasions observe some interactions by staff that were caring and kind. The environment had been adapted to provide several areas of interest which aimed to simulate 'real life' experiences for people.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 2 March 2021) and there were multiple breaches of the regulations. 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 improvements had not been made, breaches of regulations remained, and the rating deteriorated.

Why we inspected
We received concerns in relation to the recognition of and timely escalation of health concerns to professionals; Appropriate nutrition and hydration; Recruitment of staff; Infection control; Injuries sustained by people; Personal care.

As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating 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.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence the provider needs to make improvement. Please see the Safe, Effective and Well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We have identified breaches in relation to the safe care and treatment for people, management of medicines, consent, recruitment, and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

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 is therefore 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.

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, 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

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, prevention and control 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
The inspection team consisted of two inspectors and an assistant inspector.

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.

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 received 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.

We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. Throughout the inspection but not during the site visits we spoke with eight relatives. Throughout the inspection we spoke with 12 members of staff. We also spoke to the director, registered manager, and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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.

We reviewed a range of records. This included six people's care records and multiple medication records. We sampled the care records for a further eight people. We looked at six 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.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● At our last inspection we found the registered person was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they had failed to ensure systems were in place to mitigate risks for people. At this inspection, these concerns remained.

● At our last inspection we found people's care plans and risk assessments did not always contain the information needed to keep people safe. Where people had specific health conditions, there was not always an associated care plan or risk assessment. This concern remained the same at this inspection.

● For example, two peoples record we look at confirmed they lived with diabetes but there were no plans in place to inform staff about their usual blood sugar ranges, risks associated with diabetes and what to do if the risks arose. A senior staff member was unable to tell us these people's usual blood sugar range but was able to describe some of the symptoms that may present if they experienced a hypo or hyperglycaemic episode (low or high blood sugars). Other staff spoken with were not aware of this condition.

● For one of these people, their records said they were living with haematosis melena oesophagitis, encephalopathy and lymphoproliferative disease. Whilst the name of these conditions was mentioned in the care records, there was no information which explained what these conditions were, whether they posed any risks to the person and what staff should monitor for. None of the staff we spoke with were able to tell us what these were and what they should monitor for.

● At our last inspection we found one person was at risk of choking and a speech and language therapist (SaLT) had recommended they required a specific diet. However, we saw from records that this was not always followed. We found guidance on how to manage risks to people from choking was not always available, accurate or followed by staff. This concern remained at this inspection.

● At this inspection, although assessments for the risk of choking had been completed, care plans lacked clear guidance to staff about what support people required. The care plans contained no information about how a choking episode may present or the action staff should take if a person did choke. Following the inspection, the registered manager sent us an action plan stating this information would be incorporated into care plans by 31 May 2021.

● Staff were unable to tell us about all the people who needed to be given a soft bite sized diet and their food records stated their meals had been prepared to a regular consistency on a regular basis. We discussed this with the registered manager who was unable to provide an explanation. This meant that people were being given food at a consistency which was not appropriate for their assessed needs, placing them at risk of harm. We provided the registered manager time to provide us with evidence that this concern was not valid. They did not send us any evidence.

● Where people were at risk of constipation, we saw that the care records contained no information to guide staff about how this was managed, and the risks of further complications reduced. Following the inspection,

the registered manager sent us an action plan stating this information would be incorporated into care plans by 31 May 2021.

● In addition to the lack of information, we found staff were not always aware of concerns regarding people's bowels. When we asked one member of staff if a person was at risk of constipation, they told us, "Um I haven't seen that, [person] hasn't had any bowel problems or anything like that since I've been there, she's been fine with her bowel movements." However, we found records which demonstrated this person had experienced prolonged episodes of no bowel movements. Records for this person showed no bowel movement for ten days. For seven sporadic days of the 10 days they were administered their medicines but there was no evidence that a lack of bowel movement for 10 days was discussed with a health professional. Four days later the person then had a further nine days with no bowel movement. A member of staff told us, "On our handhelds if they haven't had a bowel movement in three days then it comes up so she'll need her medicines to help with going to the toilet, but sometimes she just tells us her stomach's hurting so we give it to her then." Records showed their medicine was given throughout this period but there was no evidence that a lack of bowel movement for nine and 10 days was escalated to a medical professional.

● For another person we saw records showed they had not had a bowel movement for four days on two occasions through March 2021. Despite being prescribed medicines to aid bowel movements these had not been administered.

● We discussed this with the registered manager who was unable to provide an explanation. We provided the registered manager time to provide us with evidence that this concern was not valid. They did not send us any evidence.

● Staff were checking people's clinical observations, including their blood pressure and pulse. However, it was not evident from the records for one person what action had been taken for this person when staff had checked these in March 2021 and found they were out of the persons normal range. We asked the registered manager about this during our third site visit. They said they would look into this, but they never provided a response to our question.

● Where people required specific support to reduce risks associated with their needs, monitoring records did not reflect they were receiving this support. For example, for four people at risk of developing pressure sores we found although some staff could tell us how often a person was repositioned, daily care notes provided no assurances that people had been supported to change their position as required by their planned care.

● In addition, care plans provided no information to staff about the frequency of repositioning. We discussed this with the registered manager who was unable to provide an explanation. We provided the registered manager time to provide us with evidence that this concern was not valid. They did not send us any evidence of this. Following the inspection, the registered manager sent us an action plan stating this information would be incorporated into care plans by 31 May 2021.

● At our last inspection we found risk assessments in place regarding falls did not always contain guidance to staff on what to do should the person fall. At this inspection, this information was now included in the risk assessments however, we could not see that staff consistently followed this. The assessments, registered manager and head of care told us following any unwitnessed falls medical advice should be sought but we found records for one person did not show this had happened. In addition, the assessment and registered manager told us following a fall people's observations including blood pressure and pulse should be checked for 24 hours. We found this was not happening. On the third site visit the registered manager told us they had recognised this and had recently implemented a falls management checklist for staff to complete which would remind them of what they needed to do.

● At this inspection we found information about how to reduce the risk of falls for people was not always included in their care plans. Following the inspection, the registered manager sent us an action plan stating this information would be incorporated into care plans by 31 May 2021. Where the information was recorded, we saw the measures were not in place. For example, for one person their records said a sensor

mat was being used to alert staff to their movement. However, on our first site visit we saw this person wandering the corridor inappropriately clothed and with no footwear on. No staff were present, and no alarm had gone off, suggesting this was not in place. On our third site visit, we checked this person's room and no sensor alarm was in place. A member of staff confirmed a sensor mat was not used for this person because 'they can walk and talk.'

● On a further occasion we observed one person, who had recently experienced a fall and sustained a facial injury, informing a member of staff that they felt wobbly and dizzy. The person got up to walk and although the staff member suggested they sit down; the staff member then left the room. The person who was at risk of falls and describing symptoms which increased that risk was left alone, unsupported. This meant we could not be confident staff had recognised the risk and did not act to reduce this.

● The director told us since the pandemic they had purchased and were using a fogging machine. This is a type of fumigator used to sanitise. The Health and Safety Executive provide clear guidance about the use this equipment. This states a risk assessment is required and staff using this must be competent and properly trained. The director stated he is the only one who uses this and said no training had been completed, "it's only switching a button on." We requested the risk assessment for this on multiple occasions and never received this. On 25 March 2021 the director unprompted, demonstrated the use of this to a member of the inspection team without wearing appropriate PPE.

A failure to ensure safe care and treatment for service users was an ongoing breach of Regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not managed safely. For example, we identified multiple discrepancies between the number of tablets recorded as in stock on the Medication Administration Records (MAR) and the number of tablets we counted. A senior member of staff was unable to provide an explanation for this, meaning it was not possible to determine if people had been under or overmedicated.

● The head of care told us they would investigate this and inform us of their findings. We received feedback from the head of care saying one person's discrepancies were caused by the pharmacy. The head of care told us they would contact the pharmacy to correct the error. We received no feedback about the other discrepancies.

● Where people were prescribed topical medicines, we could not see these were consistently applied. Some people's care plan for maintaining good skin integrity stated staff were to apply creams, we could not see that the daily records reflected these had been applied. The registered manager told us the computer system produces reports and said they would send us reports showing when creams were applied. The Registered manager sent us records following our third site visit. These confirmed that creams where not been applied in line with care plans. For example, one person's skin integrity care plan stated, 'creams to be applied daily'. This person had a history of a pressure sore. Their MAR showed they were prescribed a cream. We had first requested the cream records during our site visit on 8/4/21 but did not receive these until 21/4/21. For this person we noted the person had not had this cream applied from 29/3/21 until 4/4/21. It was then not applied daily, as directed by the care plan.

● For a second person, they were prescribed a cream to help reduce the risk of skin breakdown. This person was high risk of developing skin breakdown. The MAR demonstrated this had not been applied from 29/3/21. The hygiene records for this person recorded creams applied to the persons leg on 2/4/21 but it was unclear what cream this was, as this had not been recorded.

● PRN protocols guide staff when and how to administer 'as required' medicines.' We identified at least eight PRN protocols were not in place for people. This meant staff did not have guidance they required, and people were at risk of not receiving their required medicines or not receiving the correct dose.

● Where PRN protocols were in place, they did not always contain enough information to guide staff on how

to provide safe and effective PRN medicines support. For example, four people were prescribed PRN medicines to help relieve constipation. Some of these people's PRN protocols guided staff to administer the medicine if no bowel movements for 48 hours, however, did not describe how long the medicine should be administered for or when to seek medical intervention. One person's PRN protocol only stated, "staff are to check bowel charts on PCS." This person's records showed they had not had a bowel movement for four days on two occasions through March 2021 and the PRN medicines had not been given.

● One person's PRN protocol described taking, "one to three sachets daily" of the medicine with no indication why one, two or three sachets should be administered. This meant staff did not have clear guidelines to determine the appropriate dose of medicine to administer. There was a risk that not enough or too much of this medicine could be administered.

● A second person was prescribed PRN medicines which are prescribed to relieve asthma symptoms. The PRN Protocol stated, "Inhale two doses as needed." There was no other information included on the PRN protocol to guide staff of the symptoms to look out for, how many doses could be given or when to seek medical intervention.

● A third person did not have any PRN protocols in place despite being prescribed three PRN medicines. We spoke to the head of care about this, they told us, "I probably need to do those. They are not there because I am in the process of updating them." This meant care staff did not have any access to information to guide them on the safe use of this persons PRN medicines.

● We reviewed the medication administration records and noted one person had a gap on the previous day for three of their medicines. The head of care identified that she had been on shift the previous day and had forgotten to sign for the medicines. The head of care rectified this by signing for the medicines given the previous day. This had not been picked up by any of the staff administering medicines during the unsigned period.

The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager sent us an action plan which said, "Medication Staff training required for all staff regarding the use of medication for each individual."

● There was a system for the safe ordering and disposal of medicines.

● Risk assessments were in place for people who were prescribed flammable emollient creams. This meant the increased risk of fire associated with these creams was reduced.

● Medicines were stored safely. Medicines were stored in locked trolleys, in locked rooms when not in use. Medicines that have legal controls, 'Controlled drugs' were appropriately stored. Temperatures were taken daily in the medication room and were within the required range.

Preventing and controlling infection

● The provider's infection prevention and control policy was up to date. The providers policies had been updated to reflect the pandemic, but we were not always confident that the practice in the home was in line with this and people were not always protected from the risks of COVID 19 and other infectious disease.

● We visited the service over three days, the first two days were unannounced, and the third day was announced. On the first day of our inspection, the home was experiencing a COVID 19 outbreak. This meant visiting to the service was not allowed. However, on arrival we noted a person had signed in the visitors' book and had recorded they had been in contact with someone who was COVID 19 positive within the last 14 days. No one at the service had identified this until we pointed it out to them. This was addressed when we pointed it out. However, we received feedback from the clinical commissioning group (CCG) that six days later a member of staff was on site to undertake a weekly Covid 19 test but had their child with them. Therefore, we could not be confident the provider was consistently adhering to government guidance which

would help prevent visitors from catching and spreading infections. The CCG raised with this the registered manager and was informed this would be addressed.
● We were not always confident that the provider was using PPE effectively and safely. Staff confirmed and we observed that they had access to the appropriate PPE. However, during our first site visit we observed a member of staff and the nominated individual wearing their masks incorrectly. We addressed this with them at the time. The registered manager took action and issued a memo to staff about the appropriate use of PPE. We did not observe these concerns on the second site visit but on the third site visit we were required to tell a further member of staff to wear their mask correctly. Not using PPE correctly increased the potential risk of the spread of health infections.

A failure to ensure consistently applied and effective infection control and prevention measures was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● During our first site visit we noted people who were currently positive for COVID 19 were cared for in their rooms, but their bedrooms doors were not always closed, and their rooms did not have facilities to enable staff to correctly dispose of their PPE. We also found in one person room an open yellow waste bag on the floor, containing used PPE. We raised this with staff, and this was addressed immediately. On our second and third site visits we noted all rooms had facilities to enable staff to correctly dispose of PPE.
● During our first site visit we noted social distancing was not being observed or supported by staff. On the floors which contained bedrooms were small communal café areas where people were seated less than a meter apart. We raised this with the registered manager. On the second unannounced site visit we could not see changes had been made however, on our third announced site visit we observed changes to the layout of the tables and chairs had been made and people were being encouraged to social distance.
● During our first site visit we noted a number of areas in the home were unclean and very cluttered, increasing the risk of the spread of infection. We raised this with the registered manager and on our second and third site visit we observed action had been taken. The areas of the home that had been cluttered with either broken or damaged equipment and stock had been cleared. The home was cleaner.
● We were assured that the provider was admitting people safely to the service. We looked at the records for a person who were had been made aware of had been recently admitted and discussed the admission process with the registered manager. The process followed was in line with government guidance and included a PCR COVID 19 test on admission and isolation for 14 days.
● We were assured that the provider was accessing testing for people using the service and staff. People, and staff, were regularly tested for COVID 19 infection. The provider also checked people for symptoms of COVID 19 infection at least daily.

Staffing and recruitment
● Prior to the inspection we received concerns about the recruitment of new staff. We had been advised that staff were working in the home without DBS checks and were left unsupported. A DBS check is an official record stating a person's criminal convictions. They help to ensure that employers are making the right decisions during the recruitment process.
● During the inspection we looked at six staff recruitment records including the registered managers. We found the recruitment records did not confirm all staff had started employment after all relevant pre-employment checks had been completed. We requested the registered manager provide an explanation and any evidence to demonstrate these concerns were not valid. The explanation they sent, confirmed one member of staff started prior to their DBS check being received and before any references had been received by the service. A second member of staff started before their DBS was received. A third member of staff recruited as a volunteer, had no pre-employment checks. For a fourth member of staff we were told they started with a DBS from a previous employer. Government guidance states this is acceptable but 'you must:

check to see if anything had changed if the applicant is signed up for the update service'. The first recorded check that nothing had changed was a verbal discussion with the member of staff eight months after they started work. They were not registered with the update service.
● Failing to undertake all appropriate pre employment checks before allowing staff to work with people, places people at risk of being supported by staff who are not suitable.

A failure to ensure all pre employment checks were completed before staff commenced employment was a breach of Regulation 19 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager sent us an action plan which stated, 'A new recruitment process will be introduced by the manager to make sure a good skill mix is employed within the home.'

● Due to the pandemic visiting in the service had been restricted for a prolonged period. As a result, relatives were not able to provide feedback about their views of staffing levels. One told us, "It used to be every time I rang there was very quick attentions, sometimes during the pandemic there's not been somebody around as immediately, perhaps they needed to focus on other things in these strange times."
● People did not raise any concerns about staffing levels and told us they were able to call on staff when they needed their support.
● At the time of the inspection there were 27 people living in the home, across two floors. There were four care staff and a head of care on each of our visits, as well as the nominated individual, the registered manager and the director. On some of the days we visited there was also a cook and an administrator. Two care staff were allocated to each of the bedroom floors.
● Some of our observations reflected periods of time when no staff were present on the bedroom floors. For example, on the first site visit we visited the second floor where a number of people were in their bedrooms, no staff were present when we arrived and after 10 minutes of no staff being present, we pressed the call bell. Staff responded promptly to the call bell and when asked why there were no staff present, we were told it was handover and break times. Whilst staff responded promptly to the call bell, the head of care confirmed to us one person residing on this floor was unable to use the call bell so would shout out for staff attention. This meant if there were no staff present on the floor, they would be unable to access support.
● On our second site visit we observed a number of occasions where up to nine people were sat in the communal area of the bedroom floors with no staff presence. Two staff were on the floor but were supporting individuals in their bedrooms. The head of care told us that they would normally provide floating support to both floors, however, they had been instructed by the director to stay with the inspection team, despite the inspection team advising this was not necessary. This meant that on our site visits people did not have access to the usual allocation of staff.

We recommend the registered person review the deployment of staff to ensure people always have access to adequate support.

Learning lessons when things go wrong
● Incident and accidents were inconsistently recorded. We noted one person's daily notes recorded two incidents where they had slipped in March 2021 but neither of these had been reported as a fall, accident or incident and had not been identified on the accident analysis.
● We asked the registered manager to provide us with copies of staff meeting minutes, to enable us to see how lessons were learned and shared with staff. The registered manager provided us with a file that they said contained these records, however, there was no evidence within this file of any staff meetings taking place.
● We saw that one person had sustained a fall due to a wet bathroom floor. We could not see any evidence

of learning, as a result of this incident, had taken place. There was no evidence that action had been taken to prevent an incident of this nature reoccurring. For example, we asked a senior member of staff if they used or had considered non slip mats in bathrooms. They told us this had not been considered and they did not use these types of mats in the service. The analysis had not considered the use of this type of equipment.

● The accident analysis for February 2021 identified concerns accidents had occurred due to a lack of staff presence. Whilst the February 2021 analysis recorded one member of staff needed to be present on the 'floor' at mealtimes we identified this did not happen consistently. Despite identifying a risk of people experiencing accidents due to a lack of staff presence in February, we noted several times when people were left unsupported during our visits. During our site visit on 25 March 2021, we observed a lack of staff presence for at least 10 minutes on floor two, staff arrived when we called them. On 8 April 2021 we observed one staff member present for approximately 30 seconds in the 16 minutes between 12:30 pm and 12:46pm. On 15 April 2021 we observed no staff on the second floor between 3:28 pm and 3:40 pm.

● This meant we could not be confident that when things went wrong, analysis was effective, and lessons were learned and applied.

The failure to effectively assess, monitor and improve safety of the service and mitigation of risk was a breach of Regulation 17 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The training matrix showed 19 members of staff who had direct contact with people, of these, seven had not completed safeguarding training.

● Staff we spoke with said they had received safeguarding training. However, not all of them were able to tell what indications of abuse they would look out for. One told us, "I don't know, not being treated fairly not being treated right or I don't know I can't even think now" and a second said, they did not have sufficient knowledge of the spoken English language to be able to answer us. Not all staff were able to tell us who externally they could report safeguarding matters to. One member of staff when asked said, "No, not aware of any of them."

● At the time of the inspection the local authority (LA) responsible for safeguarding had opened eight individual safeguarding enquiries into the care and support provided at Bluewater Nursing Home following concerns raised external to the service. These were in the process of being investigated by the LA and one by the police. The registered manager was providing information to the LA and police.

We recommend the registered person works with staff to refresh their knowledge of safeguarding matters and reporting these.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- We were not confident that people's nutrition and hydration needs were being met.
- Care plans contained no information about the amount of fluids a person should consume in 24 hours to maintain good hydration. Although the handheld devices used by staff identified a target intake, records of fluid intake for some people reflected they were regularly offered significantly less than the target, meaning they would not be able to consume an adequate amount over 24 hours. For one of these people we saw records which stated an external registered nurse was unable to take bloods as the person had not drunk enough. The fluid records showed that the day before they had been offered approximately 800mls less than their target intake and on the day of the blood tests the daily notes recorded they had only been offered 200mls.
- We were unable to establish the nutritional intake for people. Care plans provided no guidance to staff about whether people's weight was a concern and if they required a fortified diet. Where people were prescribed supplements to take to aid their nutritional intake, records did not confirm these were given as required by their prescription. Food records provided no information about the nutritional content of the meal offered or the amount consumed. Rather than recording the meal, records stated, 'ate dinner', 'had a snack', 'pork dish' and 'ate most of their food.' For one person we saw that their food records from 1 February 2021 to 27 March 2021 show 20 main meals declined and there was no entry for 24 main meals, this meant we were not confident these were provided.
- Where people had lost weight, it was unclear what action had been taken. For one person we saw they had lost 17% of their body weight in a six month period. Their care plan did not reflect any need for a high calorie, fortified diet. We found no evidence this had been discussed with external health professionals.
- For another person we were informed they lived with a food intolerance and therefore required certain food products. On the first unannounced site visit, the service had none of these products in stock. Staff told us this person eats toast for breakfast and in order to make this soft they 'smothered' it with butter. The butter in the service was not suitable for this person's dietary needs. The nominated individual told us, 'Went to Asda this morning and they had none in stock.' They confirmed no specific food products were in the service for this person and then said, "well daughters don't think she is lactose intolerant anyway." On the second unannounced site visit, the only product available was ice cream. On the third announced site visit suitable milk and butter as well as ice-cream was in the service.

The failure to ensure nutritional and hydration needs were met was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to tell us said, they received plenty of food and enough to drink. They were happy with the food and did not have any concerns.

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

● Bluewater Nursing Home does not provide nursing care. This service only provides support for personal care needs, meaning people living in the home need external healthcare support and advice for all medical needs. Concerns had been raised with CQC prior to the inspection that staff did not always recognise a potential deterioration in a person's health condition and as such did not escalate concerns to medical professional in a timely manner. We found these concerns to be valid at this inspection.

● Haematosis means blood in vomit and melena means blood in stools, often recognised by stools being black. These are indications that health involvement is needed. We saw records for a person living with this condition, these records showed they were also taking a medicine which increased the risk of bleeding. This person's records showed they had been vomiting blood for 21 hours and 45 minutes before staff discussed with them the need for medical intervention, despite the care plan for the medicines stating this was a sign that immediate involvement was needed. In addition, we saw records stating this person experienced black stools on at least 14 occasions between 1 March 2021 and 24 March 2021. We found no evidence that this had been discussed with a health professional, despite the care plan for the medicines stating this was a sign that immediate involvement was needed.

● For another person we noted their records showed they had previously been seen by the dietician who discharged them in January 2021. However, this person then lost 2.4 kgs between 15 February 2021 and 22 March 2021. It was not clear what action was being taken and whether the dietician had been made aware of the loss. We spoke to the head of care about this on 8 March 2021 who said they were, "reviewing all records at the moment to determine who has lost weight to see who needs referring." Although we noted this person had started to gain weight again, we were not confident that timely action was taken as the weight loss was noted on 22 March 2021 and the head of care confirmed they were in the process of reviewing this almost three weeks later.

● Prior to our inspection we had been made aware of concerns a referral to district nurses about a serious injury had not been made in a timely manner. We spoke to the registered manager and head of care who told us the injury was noted when the person returned to them from hospital and a body map was completed. Due to this being a weekend the referral was made first thing on the Monday morning. We initially requested the body map on 26 March 2021 and on six subsequent occasions. We received this on 21 April 2021, and it was dated the day after the person had returned to the home. The daily records did not confirm the injury was recognised on the day the person was readmitted. We reviewed the records to determine when the referral was made and found this was not recorded. We could therefore not be confident the injury was promptly identified, and a timely referral made for health intervention.

A failure to ensure timely safe care and treatment was provided was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● The registered manager told us staff underwent an induction when they first started work at Bluewater Nursing Home. They told us this induction included competency checks of their knowledge around specific areas of care. We requested the induction records for four members off staff and did not receive these. One member of staff who had commenced employment recently told us they had received no form of supervision. This member of staff was working independently with people but had not received any safeguarding training.

● The staff training matrix recorded most staff had received numerous training courses in areas such as

pressure area care, safeguarding, first aid, moving and handling, dysphagia, nutrition and hydration. However, we could not be assured that the training had been effective, and staff had used this to inform their practice because we identified multiple concerns about the care people received. We talk more about this in the safe domain of this report.

● Prior to the inspection we had received concerns about moving and handling practices in the home. We did not observe these concerns during our site visits. However, we requested the registered manager send us copies of moving and handling competency checks for staff. They sent us records of moving and handling training but no records to show staff had been assessed as competent.

● Five staff had not completed training in dysphagia and four had not completed first aid training, which would cover managing choking. The registered manager told us they assessed staff competence for managing choking during their induction. We requested records confirming this but did not receive these.

● We identified six staff who administer medicines. We were shown medicine training and competencies for four of those staff. Two staff who administer medicines and insulin did not have any documentation to demonstrate they had medication administration training, competency assessments for the safe administration of medicines and did not have competency documentation for safe administration of insulin. One of these staff told us they had been trained to administer medicine and insulin and had received competency assessments. However, this member of these staff did not know what covert medicines was, despite saying they had received medicines training and despite there being a person in the service whose medicines could be administered covertly.

This meant that whilst staff appeared to have access to training to support them in their role, we could not be assured the registered person had ensured staff were competent and skilled to perform the roles required of them. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection we found the principles of the MCA were not consistently applied. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and this remained a breach.

● Mental capacity assessments had been completed in some area's but not in others. For example, we saw these had been undertaken and recorded for decisions about living in the home, but where people didn't have capacity to manage their own medicines, these capacity assessments and best interest decision were not recorded.

● Consent had been sought from people for a number of areas but where they were unable to provide this we saw that some consent forms had been signed under a section called best interests by a relative, but there was no recorded reason for the best interest decision.
● For one person we saw their consent form can be signed by another person and it was recorded that this person had Lasting Power of Attorney (LPA), however there were no records to confirm this, and staff told us this person had capacity to consent to their care and support. A lasting power of attorney (LPA) is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.
● Doors to the floors which contained the small café areas, bathrooms and bedrooms had keypad codes, to be able to leave the floor, as did the lift. The codes were not on display for people to be able to use these should they chose. Staff told us these locks were used for safety but were unable to clearly explain what they meant by this. One member of staff said, "well if staff are with someone, they won't notice someone has left and won't know where they are." A risk assessment for door locks was in place but despite recording this could cause people distress no plan to manage this was in place. The registered manager and staff told us people could move freely and that staff would unlock the lift for them if this was requested. However, we found occasions where staff were not present meaning that if people wanted to request this, they would not be able to. We found no records to show that people had consented to this or that people's capacity about living behind these doors had been assessed and best interest decisions made. The registered manager said some people were unable to retain the codes and others unable to reach the keypads due to where they were placed and that the support, they needed would be documented in their care records but we found this was not recorded.
● We were not confident that people could move freely between floors and had consented to living behind these locks. Following the inspection, we received an action plan which said, 'All individuals will have a care plan identifying their ability to move freely around the home and whether or not they require assistance. Risk assessments will also reflect their needs and wants.'

The failure to ensure appropriate consent was sought and the principles of the MCA applied was an ongoing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff appeared to have an understanding of the need for consent. One told us, "Everyone has the right to refuse, if someone didn't want to eat, we'd have to monitor it and record it all and I would encourage them, but I wouldn't force someone to."

● Where required deprivation of liberty safeguards had been applied for. We found some of these DoLS had conditions attached to them, but we found the DoLS conditions had not been incorporated into care plans and no plan was in place to ensure these were met. For one person, the condition stated they were to be supported to maintain contact with their social network via use of remote technology, social distancing, or face to face. The head of care told us this would be recorded in the daily notes, however, these records reflected the person had only been supported on two occasions, following a visit by the social worker, to have a video call with their relative.

We recommend the registered person review everyone's DoLS and ensure appropriate plans of care are implemented for people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Prior to a person moving into the home an assessment of their needs was completed and/or information from the discharging service was received.
● Nationally recognised tools were in the service to support the assessment of specific needs such as skin

integrity, but we could not always be confident these were completed promptly. In addition, we were not assured the assessments completed were used to inform care plans and care delivery. For example, we saw one person was admitted to the service in January 2021, but the skin integrity assessments were not completed until 26 March 2021. A care plan for their skin integrity needs was not developed until 17 February 2021 and was not updated following the skin integrity assessment on 26 March 2021. For a second person we saw a falls assessment reflected they were at high risk. It detailed staff to use a sensor mat however, we observed, and staff confirmed this was not in place.

● The registered manager told us they were aware this was an issue and had recently introduced a system that would enable staff to recognise when assessments are completed or changed, care plans are also developed or updated.

Adapting service, design, decoration to meet people's needs

● People were able to personalise their rooms as they wished, we observed this had been supported where requested. The provider supplied appropriate furniture for people in their rooms including bed, chairs, wardrobes, and bedside tables. Over bed tables were provided where needed.

● Adaptations had been made to the home to meet the needs of people living there; for example, a passenger lift connected the upper and lower floors of the building and corridors were sufficiently wide to accommodate wheelchairs.

● There was a range of communal areas available to people, including a dining area, café areas and lounges. Toilets and bathrooms were well signed to make them easier for people to find.

● Several areas of interest were available throughout the home including; a cinema, an ice-cream and waffle parlour, an aeroplane cabin and a replica railway carriage. These areas contained authentic features, to simulate a real life experience. In addition, the service also had a beauty parlour and pub area. One person told us they had not been using the beauty parlour as the hairdresser was not able to visit but this was due to the pandemic restrictions and outside of the providers control.

● Staff made use of technology to support people. An electronic call bell system enabled people to call for assistance when needed; an electronic care planning system was in place and staff had been supporting people to maintain contact with their loved one through video calls. However, one relative told us, "I know he keeps complaining to me that he is not allowed to use the phone; they haven't been too bad they let him phone me about twice a week now but that only started about four or five weeks ago. Before then I wasn't getting phone calls from him."

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. 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

- Since Bluewater Nursing Home registered in 2014 with CQC to provide care and support to people, it has not achieved an overall rating of Good or a rating of Good in the well led question. Bluewater Nursing Home has had seven comprehensive inspections and two focused inspections. This inspection is the third focused inspection. Of the previous nine inspections, the service has been rated overall Inadequate three times and overall requires improvement five times. It has been rated Inadequate in the well led question three times and requires improvement five times.
- Throughout these inspections we have found the provider has been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on three and then four consecutive occasions. In addition to this, all inspections, except the focused inspection in July 2017 had found multiple and ongoing breaches of other regulated activities regulations.
- At the last inspection the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance of the service was not effective. At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 17.
- At this inspection the rating for well led has again deteriorated to inadequate and the provider remains in breach of seven regulations. The provider has demonstrated a consistent failure to make and sustain improvements. They have demonstrated a consistent failure to meet the requirements of the regulations.
- We found the governance processes continued to be ineffective and did not identify the issues of concern we had at this inspection. These included concerns included but were not limited to, recruitment, records, risk management, medicines management, consent and a lack of person-centred care.
- The registered manager was unable to provide us with care plan audits other than one for one person which took place on 13 April 2021. The registered manager told us they had introduced a new care planning audit system, but this had not been rolled out fully. They told us we would find information about care plans in the last reviews of these. However, we found reviews were not effective and did not identify concerns. For example, for one person we found a care plan review had recorded no deterioration or decline in health and welfare, but we had seen this person had lost 3.5kgs up to this review. For a second person, their care plan review stated the care plan remained current, no deterioration in health but this person had lost weight consistently over a period of six months and we could see no action had been taken.
- There was only one medication audit available which was not dated, the person completing it had not put their name and the actions required column was blank. We found multiple concerns with medicines management as reported in the safe domain. This audit had not identified these concerns. Medicine audits

was ineffective in ensuring the safe management of medicines.
● We found multiple concerns with the recruitment records for staff. Audits were taking place monthly but did not identify these concerns and take action to address them. The recruitment audit was ineffective in ensuring the safe recruitment of staff.
● We found concerns about the nutritional support for people. Whilst people's weights were monitored, where they had lost weight, no actions were recorded, and we saw appropriate and timely action was not always taken.
● Throughout this report, we have made several references to records relating to peoples care and support which were not always sufficiently detailed to support staff to meet people's needs. There was a failure to maintain accurate and fit for purpose care records. These included missing or incomplete care plans and risk assessments that were not detailed. This could negatively impact on people's health, safety and well-being.
● We were also concerned about the accuracy of records. Following our first site visit we saw a member of staff had recorded, 'CQC was here today and saw her they are happy with the care we are giving her.' However, we had not provided this feedback and were required to inform the registered manager that at no point did CQC provide this feedback and recommended that our email be placed on the person file and the staff member be spoken with to reinforce the importance of accurate recording. The registered manager confirmed this had taken place.

● The failure to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity and the failure to maintain accurate records in respect of each person and the was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014.

● The registered manager told us of their plans about some of the changes they were going to put in place following the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People in leadership roles did not always promote the delivery of high quality person centred care. For example, prior to and during the inspection we had received concerns that there was a bullying culture towards relatives who raised concerns or did not agree to put in writing positive feedback about the service. We were informed the director for the service was rude, aggressive and intimidating towards relatives. We had also been informed this director could display intimidating behaviour towards other professionals who visited the service. During one of our site visits we experienced this behaviour by the director who was rude, aggressive, intimidating and used foul language towards the inspection team.
● Senior staff actions did not encourage a person centred approach. We observed the nominated individual not following government guidance when using PPE. The nominated individual also made dismissive comments about a person's dietary needs, as reported in the effective domain of this report. In addition, on one occasion we found a person asleep in the bed of another person. We pointed this out to the nominated individual who advised a member of staff of this. The member of staff asked if they should leave the person, as they were asleep and the nominated individual said, "yes, they're not doing any harm at the moment." This was not person centred, dignified or respectful. We were required to point out to the nominated individual that this was not appropriate. They then agreed and asked the member of staff to support the person to move beds.
● On a second occasion we had asked to use a table in the dining room and specified that this needed to be one that was not used by people. We were provided a table but at lunch time found out this was a table where a person usually sat. We suggested to the nominated individual we would move. However, the

nominated individual said, "No that's fine, we can just put [person] over there." They did not consult or communicate with this person over this decision. This was not person centred, dignified or respectful.
● We were concerned that if people in leadership roles behaved in this manner this would then influence the manner in which staff behaved towards people. We observed practice by staff that was not person centred, did not meet people's needs and was not always respectful. For example, we have reported in the safe domain of this report a number of areas where staff were not delivering the care people required.
● In addition, we observed during one lunch period, a member of staff standing and leaning over a person whilst assisting them to eat. They did not communicate with the person and at one point lifted a spoon for another person and fed both at the same time. This was neither person centred, dignified or respectful.
● On a third occasion, we observed a person walking the corridor in a t-shirt, boxer shorts and with no footwear. Staff had not noticed this. This was not dignified or respectful.

A failure to ensure dignified and respectful care delivery at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans lacked sufficient information to guide staff about the person-centred support people required and we were also concerned staff did not always read the records available to them. One member of staff when asked about a person needs said, "I don't think I want to answer that, I'm not too sure, I haven't read his care plan."
● Feedback from most relatives, staff and people was positive about the management of the service. One relative told us, "The staff and the management that we know are all really lovely people, the environment there is unique and [director] goes out of his way to stimulate the residents." A second said, "I trust them to get on and do it, I'm certainly not aware of any issues." However, one relative told us, "It's been a bit weird because for 12 months we've only seen a fraction of the place I can only assume that everything is just as it was a year ago". However, one relative told us, "They said when they got COVID my [relative] was one of the first seven tested positive and they didn't know where it had come from as no staff were positive, but when I did a zoom call, lady on the end said she'd been off with COVID, I felt like I was being lied to." One person told us, "It's a funny place really. Not easy. I'm not saying anyone's nasty because they're not. There's a variety of food. It's quite nice, they're all very nice." A second told us they liked living in the home, that they had everything they needed and were well looked after. A third person said, "such a good boy this one, he's lovely", when talking about the director. One staff member told us, "[Head of care] is absolutely lovely, and [registered manager] no issues with feeling uncomfortable or anything, they're great. That's one of the things I do really like. I really do get along with staff." A second member of staff said, "I think it's good the management in Bluewater, it's okay I don't have nothing to say about them."
● Although we observed some negative interactions, we did on occasions observe some interactions by staff that were caring and kind.

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
● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. However, we could not see that this was consistently applied. For example, we saw an incident record which stated a person had fallen on a wet floor, but no duty of candour letter and investigation had been completed. Another person's record showed a serious incident had occurred which placed the person at significant risk of harm. No investigation had been completed and no duty of candour applied.

A failure to ensure duty of candour was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers are required to display their CQC rating at their premises and on their website if they have one and we saw this was displayed appropriately.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager confirmed that no resident meetings had taken place for a significant period of time. They also confirmed relative meetings had not taken place but were planning to hold one via Zoom in the near future. The registered manager told us communication had been maintained with relatives through emails since the pandemic started and we saw examples of these emails.

● We asked to see records of staff meetings to see how staff were engaged with. However, the folder provided to us by the registered manager did not contain any staff meeting minutes but did contains emails where the registered manager had shared information with staff. This meant we could not be assured staff were provided with the opportunities to feedback.

● In July/August 2020 the registered manager sent feedback surveys to relatives and friends. We reviewed those that had been returned and noted these were mostly positive. The registered manager had completed an analysis on the 14 April 2021 after we had requested to see this. 10 of 15 surveys were returned and the registered manager had identified actions as a result of this. An action plan had been developed for discussion at a staff meeting.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were consistently treated with dignity and respect.

The enforcement action we took:

TO BE ADDED

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's consent to care and treatment was sought; failed to appropriately assess people's capacity to make decisions or ensure that decisions were made in people's best interests and involved all relevant parties.

The enforcement action we took:

TO BE ADDED

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's health, safety and wellbeing were assessed or managed, or appropriately respond when incidents occurred, to reduce the risk of reoccurrence. The provider failed to safely manage medicines and infection control. This put people at risk of avoidable harm.

The enforcement action we took:

TO BE ADDED

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 meet people's nutrition and hydration needs, putting them at risk of avoidable harm.

The enforcement action we took:

TO BE ADDED

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure records were maintained in relation to people or the running of the service which were accurate, complete or up to date. The provider failed to ensure systems in place to oversee the quality and safety of the service were robust, or that improvements were made where required.

The enforcement action we took:

TO BE ADDED

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 failed to follow safe recruitment practices, including undertaking appropriate pre-employment checks to ensure staff were suitable to work with people.

The enforcement action we took:

TO BE ADDED

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to meet their requirements to be open and honest in line with their duty of candour.

The enforcement action we took:

TO BE ADDED