Bluewater Care Homes Limited

Bluewater Nursing Home

Inspection report

143-147 Kingston Road
Portsmouth
Hampshire
PO2 7EB

Tel: 02392008855

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 30 July 2018 and was unannounced; at time of the inspection 13 people were accommodated at the service.

Bluewater Nursing Home is a 'care home' and is registered to accommodate up to 60 people. People in care homes receive accommodation and personal care as single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection. This home provides a service to older people some living with dementia or mental health needs.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. A second general manager had also been appointed who was in the process of registering with the CQC to become a joint registered manager.

We last inspected the service in October and December 2017 and rated it 'inadequate' overall. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made; however, there was a need for further improvements and the opportunity for the changes to become embedded into practice and sustained to ensure people received the care and support they required in a safe and effective way. Improvements had been made in respect of breaches of regulations 12 and 18; however, these regulations remain in breach and further improvements were required to achieve compliance. Not all risks for people were being managed safely and in a consistent manner. There were not always enough suitably qualified and competent staff deployed to meet people's needs. In respect of the other previous breaches of regulation 9 and 11 sufficient action has been taken to become complaint although there remains room for further improvement such as the development of more specific end of life care plans and ensuring legislation designed to protect people's rights was followed consistently.

Medicines were managed safely; systems were in place to ensure people received medicines as prescribed and that medicines were stored safely.

There were systems in place to protect people by the prevention and control of infection although staff were not following these in respect of one area of the home.

Staff protected people's privacy although people were not always treated with dignity or respect when they had to wait for care to be provided which caused them anxiety and distress. We observed positive interactions between people and staff throughout the inspection.

Appropriate recruitment procedures were in place and staff felt supported in their role by managers.

People felt safe. Staff knew how to identify, prevent and report abuse.

Staff had completed a programme of training.

People's nutrition and hydration needs were met. When people needed support to eat, this was provided done a dignified way.

Adaptations had been made to the home to make it supportive of the people who lived there.

People were supported to access healthcare services when needed. Staff made information available to other healthcare providers to help ensure continuity of care. Each person had a care plan that was centred on their needs and reviewed regularly.

People's needs were met in a personalised way. People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

People had access to a range of activities including access to the community. They knew how to make a complaint and a complaints procedure was in place.

Managers were visible and approachable. Staff were organised and felt engaged in the way the service was run. They demonstrated a commitment to the values of putting people first.

Visitors were welcomed and the registered manager notified CQC of all significant events.

We identified three breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities). We are currently considering our regulatory response.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Not all risks for people were being managed safely and in a consistent manner.

Medicines were managed safely; systems were in place to ensure people received medicines as prescribed and that medicines were stored safely.

There were systems in place to protect people by the prevention and control of infection although staff were not following these in respect of one area of the home.

There were not always enough suitably skilled staff deployed to meet people's needs. Appropriate recruitment procedures were in place.

People felt safe and staff had received training in safeguarding adults.

Is the service effective?

Requires Improvement

The service was not always effective.

Legislation designed to protect people's rights was not followed consistently.

Staff had completed a programme of training and felt supported in their role by managers.

People's nutrition and hydration needs were met. When people needed support to eat, this was provided in a dignified way.

People were supported to access healthcare services when needed and received the personal care they required.

Adaptations had been made to the home to make it supportive of the people who lived there.

Is the service caring?

Good

The service was caring.

The lack of continuity of care staff meant people may not always know the staff member who was providing care, including personal care, for them.

People did not feel their property was always treated with respect.

Staff interacted positively with people and understood how living with dementia may affect people.

Staff protected people's privacy and respected their dignity.

Staff supported people to build and maintain relationships that were important to them and to access the local community.

Is the service responsive?

Good

The service was responsive.

Care plans contained information to support staff to provide care in a personalised way and care and support were centred on the individual needs of each person.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

People had access to a range of activities suited to their individual interests.

People knew how to raise concerns or complaints. Where these were received systems were in place to ensure they were investigated and action taken to reduce the likelihood of recurrence.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a comprehensive quality assurance process in place, but this had not identified concerns we found during the inspection or ensured compliance with all regulations. Further time was needed to develop and fully embed the quality assurance systems in practice.

There was a clear management structure in place.

Visitors were welcomed and the registered manager notified CQC

of all significant events.

Bluewater Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 July 2018 and was unannounced. It was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had received about the service, including previous inspection reports, the provider's action plan and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with seven people who used the service and three family members or friends of people who used the service. We spoke with the registered manager, the general manager, a director of the providers company, five care staff, one activities coordinator, an administrative assistant, the chef and one housekeeper. We received feedback from two health or social care professionals who had contact with the service.

We looked at care plans and associated records for seven people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of complaints, accident and incident records and maintenance records.

We observed care and support being delivered in communal areas of the home.

We last inspected the service in October and December 2017 when we rated the service 'inadequate overall and identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in October and December 2017, we identified breaches of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Procedures to administer medicines had not always ensured that people received these safely as prescribed. Risk assessments that related to people's health and safety did not ensure that all risks were effectively and competently assessed and action had not always been taken to reduce risks to ensure the safety of people. Staffing was not planned effectively and staff worked in a task orientated way.

At this inspection, we found some improvements had been made; systems were in place to ensure that medicines were stored and administered safely as prescribed. There were improvements in the management of risks, although not all risks to individual people had been managed safely and there was a continuing breach of regulation 12. Staffing levels and organisation of staff had been reviewed although people told us they often had to wait for care to be provided and there was a continuing breach of regulation 18. Further improvements were needed and there was a need to ensure the changes made were embedded into practice and sustained to ensure people were safe at all times.

Not all risks for people were being managed safely and in a consistent manner. We spoke with two care staff about how they managed a specific choking risk for a person. Both care staff were aware of the risk however their responses were different. We viewed the person's care plan and this did not include information about the risk or how this should be managed. We discussed this with the registered manager and the general manager who were also aware of the specific risk and who confirmed no risk assessment was in place. The person was being placed at risk due to the actions of some staff and the absence of a risk assessment and management plan.

At lunch time we saw a staff member providing full assistance for a person with their meal. The person was being cared for in bed and the staff member had failed to ensure they were in a safe position to eat before commencing starting to support them. The person was lying almost flat placing them at high risk of choking. We immediately raised this with senior staff and they repositioned the person to ensure they were in a safe position to have their meal. We discussed this with the registered manager and the general manager who agreed to review meal time procedures to ensure only staff who were suitably trained assisted people who were at risk of choking on their meals. The registered manager subsequently told us the staff member had failed to follow an instruction to wait for senior staff before supporting the person with their meal.

We identified an incident when night care staff had not followed the provider's procedures for action required following a fall and head injury. A person had had an unwitnessed fall two weeks prior to the inspection. This had occurred at night and the accident report recorded that the person had banged their head and an injury was noted recording a 'lump on right side of head and slightly bruised.' The provider's procedures and best practice guidance stated that where an older person has received a head injury medical advice should be sought and the person regularly observed to identify any early indications of complications. Care related records viewed and discussions with the registered manager and the general manager identified that this had not occurred. Care staff on duty had not sought medical advice, had not

contacted the on-call manager for guidance and had not completed regular observations of the person to detect early any deterioration in their condition. The accident was reported to the general manager at 8am the following day and they contacted the person's GP at 10.00 am. Subsequent records showed that further action was taken by the general manager to reduce the likelihood of further falls and risks to the person should they try to move around independently. However, the staff on duty at the time of the fall had not taken all necessary action to ensure the person's safety. The registered manager said they were arranging additional training for care staff and were ensuring staff felt confident to contact the on-call manager should any event outside the 'normal' occur. However, until this training was in place people remained at risk because night staff, who had not received the additional training could not be relied upon to respond correctly in an emergency, or identify when there was a situation which they needed additional support from a trained member of staff or the on-call manager'.

The failure to ensure all risks relating to the safety and welfare of people using the service were assessed and managed effectively was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks were being managed safely. For example, we noted fluid thickener powder was stored securely in the locked medicines trolley and the risk management procedures in respect of a kettle in an area accessible to service users was managed according to the risk assessment. Where people were at risk of pressure injuries we saw special pressure-relieving mattresses had been provided. These were being used appropriately and people were supported to change their position regularly, thereby reducing the risk of skin damage.

We saw movement sensor equipment had been put in place to alert staff that some people may be moving around in their bedrooms. The registered manager reviewed all falls in the home monthly to identify any patterns or trends; no trends had been identified, but they described appropriate action they would take if a common theme emerged. A visitor told us how the home was managing their relative's risk of falls. They said "They are proactive in terms of his falls. They tried at least five strategies. They used a mat and frames, they had a laser system, very James Bond, and now he sits on something and they know when he stands up. He can't avoid that."

People gave us examples of when they had to wait for care to be provided and told us they felt staff were busy. For example, one person said "You don't know how long you'll have to wait. Since I've had [a new health care need] I've had to drink a whole bottle of water, on top of tea and coffee. I can't do it because I'd be wet through by the time they reached me, not because they [staff] don't want to, but they would be unable to get to me quickly enough." Other people also identified that they felt they had to wait for staff to respond to call buzzers and this caused them anxiety. Another person said "You have to wait. It can't be avoided. They [staff] come as quickly as they can". Whilst a third person said "It depends on how busy they are. You wait about a quarter of an hour. I don't think that's wrong but with others [different staff] you wait half an hour. If I need to go to the toilet, that can be worrying and painful." Another person said "It depends. They are very busy most of the time". One person described how staff would respond and turn off call bells then leave without resolving the need. They said "What I don't like is, the bell buzzes then they come in and switch it off and say they can't see to you. I say, 'Don't turn my bell off'. They turn it off and I can't reach to turn it on." During the inspection we observed care staff responding to call bells and turning them off, leaving and then returning later to address the reason for the call bell being activated. We saw a person pressed their buzzer; a member of care staff came in seven minutes, they turned off the buzzer and said they would be back to assist the person to the toilet in a few minutes which we saw did occur. However, the person waited almost ten minutes before they were assisted to use the toilet which may have been too long for some people, resulting in incontinence. Delays in responding to call bells was resulting in distress for

some service users.

The registered manager told us they were using a new dependency tool to help calculate staffing levels. The general manager showed us how people's assessments were scored and how the outcome was fed into the dependency tool to make an overall calculation. The general manager expressed their concern that although the staffing numbers met or exceeded those required by the dependency assessment tool they did not always have staff on duty with the necessary skills, knowledge and experience to meet people's needs at all times. They said the home needed more senior and experienced care staff and that, especially at night, there were often two newer junior staff on duty. An on-call manager was available when no manager was on duty in the home. The registered manager said they had reminded staff of the need to contact the on-call manager whenever any abnormal events occurred.

The failure to ensure there were sufficient numbers of suitably competent staff deployed at all times to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A healthcare professional who visited the home often told us, "The staffing levels always seem to be good; they [staff] never keep you waiting." Care staff felt there were sufficient staff to meet people's needs.

Medicines were managed safely. There were systems and processes in place to ensure that medicines were ordered and available for people to receive as prescribed. Where people were prescribed regular medicines several times each day, systems were in place to record the exact time of administration, meaning the risk of receiving these too close together was removed. At the time of the inspection we were told nobody was self-administering their medicines; however, there was a policy and procedure should people be assessed as able to self-administer their medicines. Where a person was repeatedly refusing to take prescribed medicines, their GP had been consulted and one medicine was now available in an alternative format. Where people were prescribed medicines on an as 'required basis' (PRN) staff had access to information as to when these should be administered and recording charts included a record of the effectiveness of the PRN medicine. We noted that this had not always been completed and the general manager stated they would remind staff of the importance of fully completing these records.

Medicines were stored at the appropriate temperature to ensure they remained safe to use and cooling systems were in place for use when temperature recordings showed the medicines storage area was becoming warmer. Where required, such as for liquid medicines and prescribed topical creams, dates of opening and when the medicines should no longer be used were noted on packaging. Records relating to medicines were well maintained including records of medicines received into the home, administered to people and those returned to the pharmacy when no longer required. We saw that when a GP had prescribed some antibiotics the day before the inspection, these had been obtained promptly from the pharmacy and the person was able to commence these later the same day.

Staff who administered medicines had received training to do so safely and their competency was assessed prior to their administering medicines on their own. We were told staff competency would be reassessed regularly as per best practice guidance. Medicines audits were occurring on a regular basis. These had been more frequent when they had been identifying more areas of concern; however, as they had reflected improvements the frequency had been reduced to monthly.

People felt the home was clean. When asked about general cleanliness one person said, "We've got a wonderful cleaner". Another person said they felt the home was "Very clean". A relative also commented on the home's cleanliness stating "[Name of person]'s room is always cleaned. They clean it every day."

We observed that personal protective equipment, such as disposable gloves and aprons were readily available to staff in key places throughout the home. We saw staff wore these when appropriate.

Cleaning schedules were in place for most areas of the home and records showed cleaning had usually been completed in accordance with the schedule. These included cleaning of equipment, such as wheelchairs and hoist slings. However, we could not be assured that the records were accurate; for example, records showed the sluice room had been cleaned on the day of the inspection, but we found the room was not clean. When we raised this with the registered manager, they instructed staff to clean it and reminded them of the need to complete tasks before signing to say they had done them. The sluice room did not contain a hand washing sink and staff told us they used a nearby bathroom to wash their hands. This placed people at risk of cross infection as staff had to exit the sluice room and walk along the corridor to enter the bathroom to wash their hands. If the bathroom was in use staff would then have to walk further before being able to wash their hands

The laundry room was clean, although a cleaning schedule was not in place for this. There was a clear process in place, using colour coded trolleys, to reduce the risk of cross contamination in the laundry. Staff also described how they processed soiled linen, using special bags that could be put straight into the washing machine.

Providers are required to complete an annual statement of infection control, summarising the relevant risk assessments, audits, staff training and any outbreaks of infection. We found this had not been completed and staff were using out of date guidance about infection control. We discussed this with the registered manager, who told us they were about to implement new policies and procedures that had been developed with their consultants. These would update all the cleaning schedules and include the need for an annual statement of infection control.

People told us they felt safe. One person said "Yes. I can always call a carer". Another person said "Yes, of course" When asked if they felt safe. A healthcare professional who visited the home often told us, "I've never seen any mistreatment. This is a home I'm not really worried about." One person occasionally entered other people's rooms, causing them some concern. To reduce the level of risk to people, staff used a monitoring device to help identify when this happened, so they could intervene promptly. Pre- admission assessments were used to identify any specific needs relating to protected characteristics which may make people more vulnerable to abuse and where identified the registered manager said these would be planned for within care planning systems.

The home had a policy and procedure regarding the safeguarding of people and guidance, including contact phone numbers, was available for care staff in the first-floor care office. Staff told us they had completed safeguarding training which was confirmed by records of training we received following the inspection. The general manager had completed a course for safeguarding for managers and other staff completed in house training via DVD's and workbooks. Although care staff could describe the actions they would take if they suspected abuse may have occurred they had not always acted to safeguarding people.

Recruitment procedures were in place which included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home. All potential new staff attended an interview which was completed by the registered manager or the general manager. Whilst viewing recruitment files we identified some missing or inconsistent information such as the absence of a risk assessment for one staff member where previous employers had not provided requested references

prior to their commencing employment at the home in April 2018. Following the inspection, the registered manager sent us a risk assessment and other recruitment records in respect of the missing information in the staff files.

Shortly before the inspection we received information from the local fire service following a visit they had undertaken to the home. This included information about areas that needed to be improved. Following the inspection, the registered manager sent us information confirming that action was being taken and staff had now received training and undertaken a fire drill. Personal emergency evacuation plans (PEEPS) were in place that detailed the support each person would need if they had to be evacuated. These were kept in an accessible fire proof box, together with contact details for staff and fire safety procedures. Other records viewed showed that regular checks on the home's environment and services were occurring to ensure it remained safe for people, staff and visitors.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, in October/December 2017, we identified breaches of Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where people lacked the mental capacity to give informed consent action had not been taken to comply with the requirements of the Mental Capacity Act 2005 and staff had not received regular and periodic supervision.

At this inspection, we found some improvements had been made although further improvements were needed. There was a need to ensure the changes made were embedded into practice and sustained to ensure people's legal rights were protected and staff received the support and supervision they required.

When asked if staff sought consent before providing care, one person told us, "I ask them, so they don't have to." Another person said, "I always ask them [staff], otherwise they would", while a third person felt staff asked for consent "Most of the time." A family member told us, "They respected [my relative's] wishes and never forced him to do anything without his consent. If he declined to wash, they respected his decision and would always tell us."

The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

The home used the Hampshire County Council Toolkit to record Mental Capacity Assessments (MCA) and where necessary best interests' decisions. However, this had not been used consistently for all people. For one person we found the MCA assessment in relation to 'medical treatment and health' had been completed and this showed the person did not have capacity to make decisions about their medical and health care. However, this had not been followed by a best interests' decision to show what decision had been made and who had been involved. The general manager subsequently told us they did not realise this was needed. When we discussed decision making around medicines (for which the general manager agreed the person lacked capacity), they said they thought this was done by the person's GP and Community Psychiatric Nurse as part of the prescribing process. The general manager did not realise that the home had to make a best interest decision around the administration of the person's medicines. The general manager also acknowledged that they had not completed an MCA assessment or a best interests' decision around the use of a device to monitor a person's movements.

Care staff, the registered manager and the general manager told us that another person lacked the capacity to make decision around continuing to have a favourite treat which was placing them at risk of choking. However, a formal assessment to determine the person's ability to make this decision had not been undertaken and no best interest decision had occurred. We were told the person's family had provided permission for the person to receive the treats although these placed the person at high risk of choking. The family did not have the legal authority of a power of attorney to make this decision on behalf of the person

but some staff were following the permission letter. We discussed this with the registered manager and the general manager who stated they would be reviewing the actions of staff and risk assessments for this person.

Following the inspection, the general manager completed the necessary assessments and provided us with copies of these.

For other people whose records we viewed the MCA legislation was being applied correctly to ensure their legal rights were being protected. The care plan for one person directed staff to "provide care in his best interests; offer choices; respect his decisions; involve professionals and Next of Kin for important decisions concerning health and welfare." For another person their care plan showed a comprehensive MCA and best interests decision had been completed in respect of their inability to manage their own medicines and to have an alert mat. The person's son and daughter had been consulted and their views were recorded.

Where people had capacity to make decisions, they had been invited to sign their care plans to confirm their agreement with them. One person had signed an additional agreement to use a chair alarm in the interests of their personal safety. This alerted staff if the person tried to mobilise independently.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are 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 were being met. We found staff were following the necessary requirements. The registered manager had applied for DoLS authorisations where needed and acted where conditions had been applied to DoLS. There was a system in place to ensure DoLS were reapplied for when necessary.

Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The provider's policy was for staff to receive supervision six times per year. We looked at the supervision matrix with the general manager and viewed records of supervision within staff files. The general manager explained that the supervision matrix was not up to date and that although staff had not received individual supervision they had held group supervisions and staff meetings on a regular basis. We viewed the records of these which were available for staff who had been unable to attend. However, these did not follow the provider's supervision policy of individual supervision. Newer staff had not received individual supervision or discussions about their progress. For example, records showed one senior new staff member recruited in April 2018 had not received any individual supervision. Other new staff had also not received regular individual supervision to discuss their progress or training needs. Some staff had not attended any group supervisions or received individual supervisions as required by the providers policy and procedure. Staff told us they felt supported. A staff member told us, "I had a big supervision recently and do feel supported."

Whilst most staff had been employed for less than a year, those that had been employed longer had received an annual appraisal. Records showed this had been a formal process with staff completing pre-appraisal paperwork and full records of the appraisal being kept.

People and family members were confident in the abilities of the staff. One person said "Some are very well trained. Some are very young, but they are very nice." Another person said, when asked if staff had the knowledge and training to meet their needs, "I think so, as a rule."

Care staff were positive about the training they had received. They explained that this was a mixture of DVD's

and workbooks as well as some specific face to face training. For example, they told us about some training they had received from district nurses around skin care. One senior staff member told us they had recently completed a train the trainer course for moving and handling with meant they could train new staff to use moving and handling equipment as soon as they commenced employment. All staff had recently completed face to face training for dementia which they explained had given then a greater insight into the problems people living with dementia experienced. They told us how this training had resulted in changes to the way they supported people living with dementia. The training matrix showed that most staff had completed all relevant training.

Prior to admission to the home the registered manager undertook an assessment of people's individual needs to ensure these could be met at the home including any equipment or specific adaptations that may be required. We saw copies of assessments in care files and these showed that there had been consultation with family members when these pre-admission assessments were undertaken. Specific health care needs and past medical history was requested as part of the pre-admission process and noted within care plans.

People were supported to access healthcare services when needed. A person told us "They [staff] would [contact the GP] but I don't want anyone pulling and prodding me." Another person said "I had a [specific new health care need]. [Member of staff] took me to the surgery. They [staff] are very good. When I had the problems with [specific healthcare need], I mentioned it to [the manager] and the nurse came at once and did tests. It was very good."

Care records viewed showed when staff had identified a health need they sought appropriate medical care. They also showed family members were kept informed about any changes to people's health or care needs. Staff used pre-prepared 'hospital packs' for people who needed urgent admission to hospital. These included a summary of the person's care needs, any falls they had experienced and any the medicines they were prescribed. In addition, they also included the latest handover notes recorded for the person. The registered manager told us they had received positive feedback from the hospital about the quality of the hospital packs.

The general manager told us how staff had supported a person with complex needs to have x-rays of their knees and ankles, despite the GP thinking this would be impossible due to the persons complex needs. Records also confirmed that people were seen regularly by doctors, specialist nurses and chiropodists. We spoke with two visiting healthcare professionals who both felt they were consulted appropriately and were confident people's health needs were being met.

We received mixed views about the quality of the food provided at Bluewater Nursing Home. One person said "It's lovely. I love the food. I don't eat so much now, but I still eat and enjoy my food." Another person said they enjoyed their meals and added "The cook comes up and asks what I want. If I don't fancy things because my appetite isn't good, she comes up with things to tempt me. She's very good." Other people were less positive. One said "Normally it's alright. Not always". A family member told us, "The food was good; they cooked quite a few things [my relative] liked and never offered him anything they knew he didn't like. They liquidised all his food and paid attention to his input and output."

Staff monitored the food and fluid intake of anyone at risk of dehydration or malnutrition and of all those living with dementia. The registered manager explained that this helped them spot any changes in the person's health. As part of the care planning and risk assessment process people's nutritional needs were assessed and used to develop nutritional care plans. The cook was aware of people's specific nutritional needs and was informed if people had lost weight enabling them to provide food with additional calories. People confirmed they could receive food at any time they requested this. The cook had a range of

photographs of meals which they used to help people make choices about what they would like to eat. The cook commented how useful these were with a person who was living with dementia. A 'cooling station' had been installed in one of the corridors. This included a range of cold drinks to encourage people to drink well during the hot weather that was occurring during the inspection.

Staff were aware of people's dietary needs and preferences, meals were appropriately spaced and flexible to meet people's needs. People could choose where they ate their meals. Some were happy to eat in the dining room, others in their bedrooms.

The environment was supportive of needs of the people who lived at the home. An imaginative range of age-appropriate props had been used to decorate the home; these included old tools, posters and photographs. Handrails in a contrasting colour to the walls were provided in corridors. Doors were extra wide to accommodate wheelchairs and hoists. Toilet and bathroom doors were painted in bright colours and were clearly signed to make it easier for people to find them. Bedrooms had personal images or memorabilia attached to the doors to help people find their own rooms. A large room had been converted into an old-style cinema with seats and a large screen. A dedicated dining room was available to, and used by people at lunchtime. Other communal areas including a garden were available and we saw people spending time in these during the inspection.

Good

Is the service caring?

Our findings

People identified that there had been a lot of staff changes. One person said, "The trouble is they [staff] keep leaving." Another person said "They [staff] leave in a bunch, then you have to learn a lot of new names." Whilst a third person said "They [staff] are very nice, very helpful, but they change all the time." This was confirmed by the registered manager and the general manager as well as staff records which showed that there had been lots of new staff over the past year with four staff having been employed for longer than a year. The lack of continuity of care staff meant people may not always know the staff member who is providing care, including personal care, for them and may feel less comfortable receiving essential care.

People felt staff were caring on an individual basis. When asked if care staff were caring one person said "Always. I've always got on well with them." Another person said, "They're all right", and a third said "They are perfectly kind." A healthcare professional who visited the home often told us, "Staff always seem very pleasant. They are always polite with people and the owner always acknowledges me." A thank you card sent to the service by a family member said, "All carers are very kind to [my relative] and me. It is very reassuring to know he is in such good hands."

During the inspection we spent time in communal areas observing interactions between people and care staff. These interactions were positive and valuing of people. For example, we saw a person living with dementia approach a staff member in a state of confusion. They were holding a pair of shoes and asked if they were a matching pair. The staff member reassured them and happily followed the person's conversation as their train of thought moved onto other subjects that were not always connected. The staff member showed patience and an ability to communicate effectively with the person. At the end of the conversation, the person went on their way looking more at ease and with a smile on their face. On another occasion we observed a person was supported by staff in a patient and unhurried way as they walked along a corridor. As they passed a bowl of fruit the staff member offered them an apple, which they took. The staff member then developed the conversation by reminding the person of an old saying about apples. The person responded by chuckling and clearly enjoyed eating their apple.

Staff had undertaken training to provide them with a greater understanding of dementia. As a result, the 'paper money' initiative had been developed from discussions during this training. We were told about a person who had been a gardener, and who sometimes worked on the home's garden. As a reward, they gave the person 'wages' in the form of the artificial paper money which had increased the person's sense of independence and self-worth. We were told how the 'paper money' was also being used to help a person living with dementia who became anxious if they did not have any money. The person was supported to 'pay' their own hairdresser or other 'bills' with this 'money', thereby reducing their anxiety. These examples showed that staff understood people's needs and considered how people could feel valued and less anxious improving their quality of life.

People were supported to make choices and decisions. People told us they felt staff listened to them. One person said "Yes, on the whole." Other people said, "They do" and "Yes" when asked if they felt staff listened to them. Staff told us they used 'flash cards' to aid communication with a person who was living with

dementia. In addition, photographs of the meals were used to support people to choose from the menu options.

Staff protected people's privacy during personal care. One person said, "They [staff] shut the door." Another person told us "They close the door. I can close the door when I want to."
We saw staff always knocked before entering people's rooms and kept doors closed while personal care was being delivered. Staff described additional steps they took to respect people's
privacy during personal care, including keeping the person covered as much as possible, asking the person what support they wanted and maintaining communication throughout. A care staff member said, "I would ensure the doors and curtains are closed and that they are covered up."

Staff supported people to build and maintain relationships that were important to them. Visitors told us they could visit whenever they wanted to do so and were always made to feel welcome. One person said "They [staff] are very nice to them [visitors]. My [relative] is vegetarian. I said could she come and have a jacket potato. They said, 'Of course! It's very difficult to take a person out for a vegetarian meal round here." Another person confirmed they could have visitors "whenever they like." One relative told us, "The girls [care staff] seem lovely. They let him use their phone if there's problems with his. They are friendly, approachable and lovely. They are never grumpy or nasty. They are all happy to help if you ring the bell or ask for something."

People were also supported to visit local shops, cafes and pubs meaning they could feel part of the local community. The registered manager told us they were developing links with local community groups to the benefit of people. For example, they had arranged a visit by a young scouting group that people enjoyed meeting and interacting with. A previous relative had been recruited as a volunteer activity coordinator. In addition, they had arranged for a volunteer from a local steam railway association to give a talk about its history.

People were supported to follow their faith. There was an area with the appearance of a chapel in the cinema where church services were held and people took communion. A Christian minister visited the home every two weeks to conduct a short service and staff supported a person of another faith to meet other people from their community.

Good

Is the service responsive?

Our findings

At our last inspection, in October and December 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure people received person centred care and support.

At this inspection, we found improvements had been made and the service was now compliant with this regulation; however, there was a need to ensure the changes made were embedded into practice and sustained to ensure people received the care and support they required in a consistent and person-centred way.

We identified within the safe section of this report an incident when staff did not respond appropriately after a person had a fall. On other occasions staff had responded appropriately when they had noted a change in a person's health needs. We saw in the monthly managers' report action taken by staff when a person had a TIA (small stroke). Staff had identified changes in the person and sought appropriate medical attention.

One person had behaviour support needs for a specific behaviour need. Staff kept monitoring charts to help identify the triggers and effective interventions. This information had been used to develop the person's care plan and the way staff responded. For example, staff identified that the person responded well to music and they described how they used this when the person became anxious. The records had also been used to inform healthcare professionals who were working collaboratively with staff to establish a supportive medicine regime for the person. Each time a new medicine was introduced, or the dose changed, staff recorded the effects and fed them back. This process was still on-going, but had already helped calm the person at certain times of the day.

Care staff were responsive to people's changing daily needs and wishes. For example, two care staff were clear about the action they should take if a person living with dementia refused essential personal care. They stated they would leave and return shortly after or ask another care staff member to try to provide the care. Care staff said this usually worked well and showed they could adapt their planned routines to meet people's individual wishes. Bathing charts showed that people were supported to take showers or baths according to their individual preferences. For example, some people chose to bathe, while others preferred to shower; some people had showers every day, while others had them once a week.

Prior to moving to the home, one of the managers completed a comprehensive assessment of the person's needs. This included falls, continence, identified risks, behaviour support needs, skin integrity, nutrition, moving and handling needs and psychological support needs. This information was then used to develop a care plan for the person. A relative confirmed they had been consulted about care plans. They told us "They [the manager and staff] speak to me about planning and what's needed and what's best for [my relative]. They ask if everything is OK and if he needs anything. If they change things, they talk to me about it."

Care records were developed using a computerised system. Hard copies were kept as a back-up, but the latest version was always to be found on the computer. Staff used hand-held devices to input the care they

delivered and could access a limited range of information about the person's needs on them although they also had access to the main information on the computer. We observed that staff followed the guidance in people's care plans. For example, one person's care plan said the person preferred to hold the hands of staff when mobilising, rather than the handrails and we saw staff doing this consistently.

Care plans followed best practice guidance. For example, they used recognised tools to assess people's nutritional needs and their skin integrity. The registered manager was an accredited continence assessor. Following an assessment of a person's continence needs, they were then able to access continence products for them and could seek other support when needed.

A family member was positive about the care their loved one had received at the end of their life. They said, "We were very happy with his care here". They described how they had been made welcome to visit at any time and were offered refreshments when they did so. Another family member of a person who had received respite care towards the end of their life told us staff had been supportive when the person approached the end of their life. They said, "Staff were absolutely brilliant; I can't fault them in any way. They thought of everything and discussed things with us that might help him and all of our wishes were met."

People were supported to receive appropriate care at the end of their life although specific end of life care plans were not always in place. We viewed the care plan for a person who was approaching the end of their life. There was some information showing the person had expressed a wish not to be admitted to hospital; however, the specific section of the care plan relating to end of life care contained limited information about how their individual needs relating to spiritual or specific wishes should be met. Whilst there was some information in other sections of the care plan this had not been pulled together to provide specific guidance for care staff as to how the person wished to have their needs met as they approached the end of their life. We also viewed another care plan for a person who had received care at the end of their life. This was comprehensive. It showed staff had liaised closely with the GP and the community nurse. A 'do not resuscitate' request was in place, together with an advanced care plan which specified where and how the person would like to be treated should they become unwell.

Activities were partly organised by a part-time volunteer who supported people three afternoons each week. At other times care staff organised activities. One person said "Whatever it lacks it's made up for by the cinema. I'm not mad about the activities, they're like for a kindergarten, not for adults. But with the films you can put on whatever you like." Another person said "[The activities coordinator] does different things and we all join in." A third person said "I've been to some of the quizzes. A chap comes in to sing. He sings old songs, he's quite good." One person told us they no longer engaged in the organised activities as they did not enjoy them and said "I would rather watch films on my TV." A family member told us their relative enjoyed the activities. They said, "He made friends with other residents and with staff too. It was the most social time he ever had outside of work."

Photographs confirmed that people were supported to access a wide range of activities, including games, arts, crafts, quizzes, films and reminiscence. The activity coordinator told us people were very competitive and particularly enjoyed playing skittles and other "throwing games". Trips were also organised to local attractions, including coffee shops and pubs. In addition, external entertainers, such as singers visited each week. Staff told us about a recent visit by a young person with their Shetland pony which had been particularly well received and this was confirmed by photographs of the event.

People said if they had any complaints or concerns they would speak with the registered manager. A complaints procedure was in place and complaints forms were available in the entrance lobby. The registered manager told us the complaints procedure was included in an information pack given to people

when they move to the home. This was available in large print if needed. We viewed records of recent complaints; we saw these had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. For example, a complaint relating to the inappropriate use of a mobile phone by a staff member resulted in disciplinary action. The registered manager also kept a record of informal comments from people to help identify any common themes.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, in October/December 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to have effective governance systems to ensure the safety and quality of the service provided.

At this inspection, although we found some improvements had been made there was a need for further improvements and for the changes made to become embedded into practice and sustained to ensure people received the care and support they required in a safe and effective way. As detailed in previous sections of this report, improvements had been made in respect of breaches of regulations 12 and 18, however these regulations remain in breach and further improvements were required to achieve compliance. Not all risks for people were being managed safely and in a consistent manner. There were not always sufficient competent staff deployed to ensure people's needs were met promptly and safely. In respect of the other previous breaches of regulation 9 and 11 sufficient action has been taken to become complaint although there remains room for further improvement such as the development of more specific end of life care plans and ensuring legislation designed to protect people's rights was followed consistently.

Since the service was registered in 2014, it has not received a rating above requires improvement. Following our last inspection, it was rated Inadequate in two key questions and overall, resulting in it being placed in Special Measures. The registered manager acknowledged that further work was needed to improve standards overall and had developed an action plan to help achieve this.

The provider's quality monitoring systems and processes were not yet sufficiently developed or effective to fully assess, monitor and improve the quality and safety of the services provided at the home. The registered manager told us they had recently purchased new systems to help them monitor the quality of the service and were working with an external consultant company. They identified that whilst this had identified positive aspects of the service it had also helped them identify where improvements were needed such as in respect of the policies and procedures which they had acted on. The registered manager also identified that the presence of a second manager was helping them to ensure all management tasks were addressed which they acknowledged they had previously been unable to do without additional support.

The provider's failure to operate fully effective systems to assess, monitor and improve the service was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some audits were effective in bringing about improvement. For example, an infection control audit identified that areas of the home were "cluttered" and bowls were being stored in a bathroom rather than in people's rooms. We saw both issues had been addressed. Medicines audits were comprehensive and where issues had been identified these had been addressed. Key workers completed weekly checks to help ensure people's clothes were clean, that their rooms were tidy and that their personal care needs had been met. The registered manager had introduced a "10 at 10" meeting which was held each day for key staff in each area of the home to discuss immediate concerns relating to people, for example those that needed to see a

doctor, events planned for the day and any staffing issues. This helped ensure the smooth running of the service on a day-to-day basis.

Following our last inspection, the provider acted to improve the governance of the home. During an initial discussion with the management team the provider reflected on the previous inspection and issues this had identified. They said the service had changed and now "listened" and was "more proactive". He said they acted immediately when concerns were raised and cited an example of dealing with the risk posed by stairs which was immediately addressed once we had identified this to them. The provider stated they had been working with external health and social care consultants to improve the quality of the service provided and had brought in a new general manager to identify and drive improvement. The registered manager told us the provider and nominated individual (the provider's legal representative for the home) were now less directly involved on a day to day basis with the home. The provider was kept informed about the home thorough a monthly report produced by the registered manager. We were provided with a copy of a recent report. This covered all key areas of the service. The new general manager was in the process of applying to CQC to become a joint registered manager with the existing registered manager. They identified that they worked well together and had agreed individual responsibilities to ensure all management tasks were completed. A staff member felt the service had improved since the new general manager had started. They told us "[The new general manager] is very good and helps us a lot when [the registered manager] is not there. If I have a problem, I can call her or [the registered manager]; they are on call 24/7."

Care staff told us about improvements which had been made to the care recording system which they felt made it easier for them to more accurately record the care they had provided for people. However, we identified areas where recording had not been completed such as following a person having an unwitnessed fall where the person's electronic daily records made no reference to their fall which was only recorded on the separate paper accident report. The registered manager acknowledged that there was a need to improve staff recording and to generally increase the skills and knowledge of care staff.

Policies and procedures had been purchased from an external company and the registered manager was in the process of reviewing new policies which covered all aspects of the service. They were ensuring these reflected the way the service was organised and run and where necessary amending these to better reflect this information.

Providers are required to act in an open and transparent way when people come to harm and should provide written information and an apology to the person or their legal representative. We identified this had been done verbally for a person following a fall, but the information had not been put into writing. We raised this with the registered manager and by the end of the inspection, this had been done.

People were positive about the registered manager. One person told us "If I had to I would speak to [the registered manager], she is very nice and very helpful." A family member told us, "If I ever needed to put [a loved one] in a home, I would have no hesitation putting them here. It's more of a sanctuary than a care home." A healthcare professional who visited the home often told us, "It's lovely here and seems well organised." Some people were unsure who the registered manager was and spoke about the provider when asked about the manager saying, "I don't have much to do with him, but if I had a problem, yes I would ask someone if I needed help". Whilst another person said "Yes. I can talk to him."

The registered manager said people were consulted in a range of ways about the way the service was run. These included regular "residents' meetings", yearly questionnaire surveys and individual discussions with people and their relatives. The result of the formal feedback from questionnaire surveys was analysed and shared with people, together with any action taken in response. For example, following feedback about

activities, we saw these were now advertised to people and arrangements had been made to meet one person's interests. The registered manager told us they had also introduced a 'Relatives gateway'. This allowed those relatives who had a Lasting Power of Attorney for health and welfare to access part of the care planning system for their relative and the daily records. However, people felt they were not always kept informed about changes in the service. One person said, "Sometimes you hear about things rather than being told about them, but they're all right". Another person said "I don't know. They expect me to know."

Staff felt listened to and there were monthly staff meetings. Minutes of staff meetings showed staff were kept up to date with changes to the service. They were also given an opportunity to raise concerns and make suggestions for improvement which managers had acted on. One staff member told us they were "passionate" about dementia and had suggested the "baby corner" that had recently been set up for people who gained comfort from interacting with dolls.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way that they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. A 'Service user guide' was provided to people which the registered manager told us could be provided in large print format on request. A staff member told us they also used visual aids, such as picture menus, to help people understand their food choices. This showed the home had started to adapt the communication tools they used to help people understand information and make choices.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person has failed to ensure all risks relating to the safety and welfare of people using the service were assessed and managed effectively.

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's has failed to operate fully effective systems to assess, monitor and improve the service.

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person has failed to ensure there were sufficient numbers of suitably competent staff deployed at all times to meet people's needs.

The enforcement action we took:

We have added conditions to the provider's registration.