Blossom Care Home Limited

Blossom Care Home

Inspection report

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16 March 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Blossom Care Home took place on 13 and 16 March 2017 and was unannounced. The location had been previously inspected in November 2016 and was found to be 'Inadequate', with multiple breaches of regulations relating to person centred care, safe care and treatment, governance, staffing, consent, premises and equipment and meeting nutritional and hydration needs. In addition, we found a breach of the Care Quality Commission (Registration) Regulations 2009 because the registered provider had failed to notify the Care Quality Commission of specific incidents. The service was placed into special measures.

During this inspection, we checked to see whether improvements had been made. We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, premises and equipment, staffing, governance, consent and person centred care. We also identified a breach of the regulation relating to dignity and respect.

Blossom Care Home is a residential home, registered to provide care for up to a maximum of 20 people. There were 12 people living at the home at the time of our inspection. On the first day of our inspection, there was no management presence at the home. At 9am we were told the interim manager was due to arrive. However, at 10.15am we were told the interim manager was absent from work due to sickness and the deputy manager was on leave. On the second day of our inspection, the interim manager had returned to work.

The service had a registered manager at the time of our inspection. However, the registered manager had been absent from work due to maternity leave since March 2016. The interim manager told us the registered manager was not returning to Blossom Care Home.

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. The registered provider was not present at the home on a day to day basis and had engaged an agent, who had employed an interim manager. The interim manager had been in post since November 2016.

The staff we spoke with understood the signs to look for which may indicate potential abuse and staff were clear about who they would report concerns to.

We found some risks to people had not been assessed and care plans were not sufficient to ensure everyone's needs could be met safely. Some care records did not contain information which would enable staff to safely assist people to move. A person who was at risk of choking did not have an associated risk assessment in order to provide staff with the information they would require to safely assist the person. These concerns were highlighted at the last inspection.

The premises were not safe and an enforcement notice had been issued by the West Yorkshire Fire and Rescue Authority. Some work, which was required to meet the requirements of the enforcement notice, had not been completed. Some windows on the first floor were open wide, well beyond the recommended limit, and this presented a risk to people. Other building safety works were outstanding such as gas safety and lift maintenance works.

Staff had been safely recruited but we found the deployment of staff was not always effective.

Recording of the administration of medicines was inconsistent and not always in line with the registered provider's own policy.

There was a lack of staff support, supervision and training. There was no training matrix in place to provide an overall view of training. Some staff had not received training in areas such as safeguarding, the Mental Capacity Act 2005, fire safety and basic first aid. Evidence of staff supervision was lacking and staff told us they had not received regular one to one supervision in order to monitor their performance and development needs.

People were not supported to have maximum choice and control of their lives and staff did not support people in the least restrictive way possible. The registered provider was not acting in accordance with the Mental Capacity Act 2005 (MCA). Some people had decisions made on their behalf without the principles of the MCA being followed. Some people were being deprived of their liberty without authorisation or the necessary safeguards in place.

People received support to access additional healthcare such as GPs and district nurses.

Although people told us they felt staff were caring, our observations were that staff did not always treat people with dignity and respect. We observed some staff providing care and support without communicating with people.

People's human rights were not always upheld. We had identified this as a concern at the last inspection in November 2016 and had discussions with the registered provider and their agent, and they had failed to make improvements.

Some care plans contained personalised information to enable staff to provide effective care. However, some people's care plans required updating and were lacking essential information, such as risk assessments and specific plans of care. This had been highlighted as a concern at the last inspection.

We found there to be a lack of meaningful activities and two people told us told us they were bored.

People were able to make their own choices, such as what to eat, what to wear, where to sit and what time to get up and go to bed.

We found continued inadequate management of Blossom Care Home. There was a lack of management oversight. For example, regular safety checks had not been completed, some audits had not been completed, there was a lack of staff support, the premises were unsafe, risks were not assessed, appropriate records were not kept and emergency plans were not in place.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. Services in special measures are kept under review and further enforcement action may be taken as appropriate.

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

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.

Risks to people had not always been assessed.

The premises and equipment were not safe.

Staff were not always deployed in a safe, effective way, in order to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive regular support, training and supervision.

The registered provider was not acting in accordance with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

People were not offered regular drinks and this increased risk of dehydration.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were caring.

We observed people were not always treated with dignity and respect.

Some people had not accessed advocacy when it would have been appropriate to do so, such as when decisions were being made on their behalf.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of meaningful activities.

Some care plans lacked details and people had not been involved in reviews of their care.

A complaints policy was in place.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of systems and processes in place for auditing the quality of service provision.

There was a lack of management oversight at the service.

Previous breaches of regulations and areas identified as requiring improvement had not been addressed.

Blossom Care 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.

The inspection took place on 13 and 16 March 2017 and was unannounced. The inspection was carried out by two adult social care inspectors on the first day and an adult social care inspector on the second day.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority contracts, commissioning and safeguarding teams as well as information we received through statutory notifications.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with five people who lived at the home, four care and support staff, the cook, a member of domestic staff and the interim manager.

We looked at eight people's care records, five staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Inadequate

Is the service safe?

Our findings

A person we asked told us they felt safe living at Blossom Care Home. We were told, "I do feel looked after here, but I preferred [name previous residence]. I feel safe."

The interim manager and the staff we spoke with demonstrated an understanding of safeguarding. Staff were able to identify potential signs of abuse and were clear about reporting procedures. A member of staff told us they would whistle-blow and share their concerns with the Care Quality Commission if they had any concerns, which they felt were not acted upon.

Three recent allegations of financial abuse by Blossom Care Home had been investigated by the local authority safeguarding team. The allegations were fully substantiated and had been reported to the police. A safeguarding review was due to be held in relation to the actions taken by the end of April 2017.

The previous two inspections found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risk assessments were inconsistent and, in some cases, no risk assessments had been completed despite risks being present. During this inspection we found a continued lack of risk assessments.

A person was receiving care assistance in relation to a stoma and colostomy. This is care that is provided following a surgical procedure, which results in an opening, known as a stoma, on the person's abdomen. A colostomy bag is then placed over the stoma. There had been no assessment of the risk in relation to providing this care and support. This was also highlighted as a concern at the last inspection in November 2016.

At the previous inspection we found a person who was identified as being at high risk of falls who had no risk assessment relating to falls. The person required the assistance of two members of staff to transfer from their wheelchair yet there were no moving and handling plans in place to enable staff to do this safely. We found this person's care record had not been updated since the previous inspection and there remained a lack of risk assessment or moving and handling guidance. The interim manager told us these would be completed when the care plan was updated but this had not yet been done. This meant there was an increased risk to the person of poor moving and handling. We saw in another care plan a person had a falls risk assessment in place and a detailed moving and handling plan.

At the last inspection, we saw a person ate in a way which put them at risk of choking. The person's care plan stated, '[Name] tends to eat their food very fast and tends to overfill their mouth and then has trouble swallowing it and has been known to choke so staff have to observe.' However, there was no associated risk assessment in relation to the risk of choking, advising staff of what to do or what actions to take to reduce risk. At this inspection we found there continued to be no assessment of the associated risks for this person. The interim manager had obtained a generic risk assessment tool in relation to choking but this had not been completed in relation to the person.

We noted a person had not been assisted with their continence needs for a prolonged period of time during our inspection. Records we saw showed from 1 March to 8 March 2017 this person was provided with continence care in the evening only, on six of the eight days. This was despite the person's care plan stating, '[Name] has no control over bladder. Staff regularly ask if [name] needs the toilet.' Records and our observations indicated the person was not assisted regularly with their continence needs. This meant the person was not receiving appropriate care.

We observed an incident of unsafe moving and handling. Three staff assisted a person to transfer from their wheelchair to a chair, using a stand aid. Two staff appeared to take the full weight of the person, because the person was not able to stand from the wheelchair with the assistance of the stand aid. The manoeuvre was clumsy and unsafe, and the person and staff were at risk of injury. We raised our concern with one of the staff members, who told us, "[Name]'s been assessed for a hoist but she hates it. It breaks our back." The member of staff said, "I was worried then," (in relation to the safety of the person). Furthermore, we saw there were no footplates on the wheelchair used for the person. On the second day of the inspection, the interim manager told us they were not sure why the footplates had been removed but they had advised staff they must be used. Following the inspection, the interim manager forwarded us evidence to show staff had been reminded of the need to ensure footplates were not removed from wheelchairs. We raised our concerns regarding poor moving and handling with the interim manager and advised the person should be reassessed in relation to appropriate moving and handling methods.

The above examples demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because assessment of risks to the health and safety of people were not carried out and were therefore not mitigated, and care and treatment was not provided in a safe way.

The previous inspection found no analysis of accidents and incidents took place. We found the same during this inspection, although the interim manager had devised a monthly accident audit tool. This tool had not yet been used to analyse any information. We asked to see records relating to any accidents or incidents, such as falls. The interim manager advised these were entered into an accident book. However, they were unable to locate this during our inspection.

At our last inspection in November 2016 we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to premises and equipment. At this inspection we found continued concerns.

On the first day of our inspection, the windows in some first floor bedrooms were wide open, well beyond the 100mm limit, recommended by the Health and Safety Executive, where vulnerable people have access to windows large enough to allow people to fall out and be harmed. The restrictors fitted to the windows had been by-passed. Although a person would need to climb onto the windowsill in order to climb out, it meant there was a risk people could climb out and fall from windows. The doors to these bedrooms were not locked. Furthermore, records showed a person had been given Lorazepam, a drug used to treat anxiety, on 4 March 2017 because they were, 'Taking keys out of other service users' doors and going into their rooms trying to get out of their windows.' We raised our concern immediately with the senior care worker and advised urgent action be taken to reduce this risk. On the second day of our inspection we saw the windows were closed and the interim manager told us they would alert the agent and arrange for this to be rectified immediately.

The previous two inspections found concerns regarding a lack of regular safety checks within the home, such as testing fire alarms, emergency lights, call bells and water temperatures. At the last inspection in

November 2016, the interim manager advised they were advertising for a maintenance person who would undertake these tasks but this role had not yet been filled. We were also told this at the inspection in February 2016. This inspection in March 2017 found, although portable appliance testing of electrical items had taken place, the gas safety record had expired in January 2017 and the interim manager told us gas safety had not been re-tested. We asked whether safety systems such as fire alarms and nurse call bells were regularly tested. The interim manager confirmed regular testing did not take place and added, "We don't have a maintenance person dedicated to the home." This put people at risk because systems were not regularly tested to ensure they were in good working order.

Records showed the lift had been serviced in January 2017 and the engineer identified actions which were required, such as the buttons for floors needed replacing as they were unidentifiable, there was a fault in relation to hydraulics and oil levels and a 'single phase isolator needed, pressure dropping and valve block.' We asked the interim manager to confirm whether this work had been undertaken or begun. We were told this had not begun and that a quote had been obtained and sent to the agent. The interim manager told us they would, 'Chase this.'

A fire enforcement notice had been issued to the registered provider on 18 October 2016 because people were unsafe in the event of a fire. The home was required to comply with notice by 9 January 2017. The registered provider had requested, and been granted, an extension to meet the requirement of the notice until 10 April 2017. The notice had not been met at the time of this inspection.

The above examples demonstrated a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because premises were not fit for purpose in line with statutory requirements and were not properly maintained.

Fire procedures were displayed on the walls throughout the home. At the last inspection in November 2016 we found personal emergency evacuation plans were not in place for everyone living at the home. We found these had now been developed and included information such as the person's awareness, ability to see and interpret exit signs, whether the person could hear the alarm and the assistance they required. These had been developed following the previous inspection and would provide staff with information they needed to assist people to evacuate the building in an emergency.

There was a senior care worker and a care worker employed from 8am to 8pm, with an additional care worker deployed between 10am and 6pm, as well as a cook and domestic staff. We found staff deployment to be ineffective at times. For example, on the first hour of our inspection, no staff entered the lounge area, where seven people were sitting. We observed staff on many occasions sitting together at a dining table, either talking, completing records or eating, and not providing care and support to people. We were told six people required two staff to assist with their care needs. This meant between the hours of 8am and 10am and 6pm and 8pm, if a person was being assisted by two care staff, there were no care staff to provide assistance to other people.

We discussed staffing levels with the interim manager and asked whether a dependency tool was used. A dependency tool can be used to determine what staffing levels are required. We saw dependency scores were included in the new care plans. However, these had not yet been incorporated into a dependency tool in order to determine staff numbers. These scores considered the person's needs in relation to mobility, dressing, feeding, eyesight, hearing, pressure ulcer risk, continence needs, communication, social dependency and behaviour. This resulted in a dependency score. The interim manager told us the scores would be updated monthly and these would be used to help determine staffing numbers.

At lunchtime we observed all staff sat and ate their lunch together, leaving no staff providing care and support to people during this time. We heard a care worker tell a person, "You'll have to wait. We're still having our dinner," when the person requested assistance.
A member of staff we spoke with told us, "I think there should be more staff on."

The above demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because staff were not deployed effectively in order to meet people's needs.

We inspected three staff recruitment files. We found safe recruitment practices had been followed. For example, the manager had ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at how medicines were managed and administered. The person responsible for administering medication had received specific training to enable them to do so in a safe way. Medication Administration Records (MAR)s and the trolley containing medicines were well organised. Medicines were stored securely, with only the senior care worker having access. Storage temperatures were checked regularly, which helped to ensure medicines were stored safely. The care worker administering medicines demonstrated good infection control practice. We checked a random sample of medicines and found stock levels reconciled with the records.

One person was prescribed Lorazepam on a 'when required' or PRN basis. We asked whether a PRN protocol was in place. A PRN protocol is a plan which describes when the person should take a specific medicine, the correct dose and how soon it can be taken again. We were told, 'No, no protocol.' When we raised this concern with the interim manager we were shown a blank PRN protocol form and advised they were intending on implementing them. Having a PRN protocol would help to ensure 'when required' medicines are administered only when it is appropriate and safe to do so.

At the time of our inspection, the person had been given Lorazepam four times since 11 February 2017. On each occasion an 'ABC chart' was completed. The ABC approach is a way of characterising events and resultant behaviours. We found a lack of evidence to show appropriate strategies had been applied before the administration of Lorazepam and we shared this concern with the interim manager. They agreed to look at the records and address this.

Records showed the time of administration of PRN medicine was not consistently recorded. We highlighted this to the interim manager who agreed to speak to the staff member concerned. The registered provider's PRN policy stated, 'The time medication is given and the amount given must be recorded on the MAR chart.' It is important to record the times that medicines are administered to ensure they are given at safe intervals. This meant the recording of medicines was not always in line with the registered provider's policy.

Some people were prescribed topical creams. Creams were kept in people's rooms and the senior care worker told us these were applied by care staff. We asked whether body maps were in use so staff knew exactly where to apply the cream on the person's body. We were told body maps were not in use and this meant there was an increased risk that creams were not applied correctly. The staff member applying the creams was not always the member of staff who completed the MAR and this meant there was increased risk of records not being accurate in relation to the application of creams. We highlighted this to the interim manager, who advised they were in the process of consulting a different pharmacy to supply medicines and they were looking to improve the system of recording.

The above examples demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because staff did not always follow procedures in relation to the recording of the administration of medicines.

The home appeared tidy and uncluttered. However, we noted a strong offensive odour on the first day of our inspection. This lessened as the day continued and a domestic worker was seen cleaning. The odour was less obvious during the second day of our inspection.

We observed a care worker with long, false finger nails. We highlighted this to the interim manager who told us this was contrary to the registered provider's policy and advised they would address this with the staff member. False nails may pose an increased infection control risk to people.

We observed staff using personal protective equipment (PPE) when providing care, and a staff member told us they had access to, "Plenty of PPE." This helped to reduce risks associated with the control and spread of infection.

Inadequate

Is the service effective?

Our findings

We asked a person whether they felt staff had the skills and knowledge to provide effective care. We were told, "They seem to know what they're doing I suppose."

A staff member told us, "I feel I have the right skills to do this job."

Previous inspections in February 2016 and November 2016 found a lack of staff support, training, professional development and supervision, resulting in a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found continued concerns at this inspection in March 2017. The interim manager told us there was no training matrix in place, which would enable an overarching view of staff training. We reviewed five staff training files and found staff had received training in moving and handling and dementia awareness. However, there was no evidence of safeguarding training. Following the inspection, the interim manager forwarded copies of training certificates for staff who had recently completed training. This provided evidence that four out of 14 staff who were employed at the home, had completed safeguarding training. The interim manager advised further training had been booked for April 2017. Only one member of staff had completed training in relation to the Mental Capacity Act 2005. Two of the staff records we reviewed had no record of fire safety training and three staff had no record of basic first aid training.

The last inspection in November 2016 found concerns staff were providing care for which they had not been trained. We asked a care worker whether they provided stoma care to a person and they confirmed this to be the case. Another staff member said, "Yes we change the bag and everything. We clean it and change it." However, both staff confirmed their competency had not been assessed and they had not received any training or input from district nurses to show them how to do this safely. This meant staff were providing care for which they had not received appropriate training.

We asked staff if they had regular one to one supervision. A staff member shook their head to indicate they had not, but said, "We can go to the manager if we need to." One staff member told us they had not had supervision since July 2016. The interim manager told us 14 care and support staff worked at the home and we found records which indicated five staff supervisions had taken place since the last inspection. This was despite concerns being raised at the last inspection regarding the lack of staff supervision.

The above demonstrated a further continued breach of Regulation 18 because staff had not received appropriate support, training, professional development, supervision and appraisal as was necessary to enable staff to carry out the duties they were employed to perform.

Some signage was displayed around the home, to assist with orientation. A display board in the dining area showed the menu options. On the first day of the inspection, the board was blank and had not been completed. On the second day of the inspection the board contained details of the menu for 14 March 2017, not the actual date which was 16 March 2017. This could confuse people living with dementia and cause increased anxieties.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The last inspection in November 2016 found a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent and the MCA.

At this inspection we checked whether the service was working within the principles of the MCA. Only one member of staff had received training in relation to the MCA and the staff we spoke with showed a lack of understanding of the Act.

The last inspection found one care plan stated, '[Name of relative] is next of kin so anything regarding [Name] needs to be approved by them.' However, the person had capacity to make their own decisions regarding their care. This practice contradicted the principles of the Mental Capacity Act 2005 and we highlighted this to the interim manager. At this inspection we found the care plan had not yet been addressed.

In order for a decision to be made on a person's behalf, in line with the MCA, it must first be established the person lacks capacity to make that decision for themselves. We found some people had decisions made on their behalf, without mental capacity assessments taking place. At the last inspection in November 2016 we found staff had received specific instructions on what to do regarding a person's particular behaviour, based on a decision which the care plan stated had been made in the person's best interests. However, there was no mental capacity assessment to show the person's capacity had been assessed and there was no date which indicated when this might be reviewed. At this inspection we found this had not been addressed. This showed decisions were made on behalf of a person without adhering to the principles of the MCA 2005.

We highlighted to the interim manager that we could find no decision specific mental capacity assessments in any of the care plans we inspected, including new updated care plans. The interim manager advised they were aware of this and this was something they were working towards. The interim manager confirmed no-one living at Blossom Care Home had a DoLS application either in process or approved. The was despite some people living at the home who lacked capacity to consent to living there and at least one person showing signs of trying to leave the home. This meant people were being deprived of their liberty without authorisation or appropriate safeguards in place.

We observed staff, at times, provided care to people without obtaining consent. We saw the consent sections of some care plans had not been completed, including the new updated care plans. This meant the registered provider had not ensured people consented to their care and treatment.

The above examples demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because care and treatment was not always provided with the consent of the relevant person and staff did not act in accordance with the requirements of the MCA.

We looked at whether people's nutritional and hydration needs were met. The last inspection in November 2016 found a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to people's nutritional needs. At this inspection we found people who were at

risk of malnutrition were weighed regularly and the cook had improved their knowledge.

We spoke with a person whose first language was not English in their preferred language. They told us they enjoyed the food and they were given their food choices, in accordance with their cultural preferences. Another person told us, "We have a right good dinner every day."

The cook was knowledgeable regarding people's dietary needs. They told us they used specific produce for certain dietary requirements. Details of people's dietary needs were kept in the kitchen and there was a communication book in use for kitchen staff. This helped to ensure people's dietary needs were met. We saw regular quality checks took place in relation to food safety such as temperature checks and cleaning, and checks on kitchen appliances. Meat produce was kept separate from other items. Halal meat was procured and cooked appropriately for people who required this. We saw a fresh supply of fruit and vegetables. The cook asked people for their choices of foods. People were given a choice of two options at mealtimes and there was a choice of juices available.

We saw a person's nutritional assessment clearly stated the person liked to eat their meals, 'In the lounge with a tray table.' We observed this in practice.

On the first day of our inspection, no-one in the lounge area was offered a drink between 9.15am, when our observations began, and 12pm when staff began to serve lunch. This meant people were at risk of dehydration. We highlighted this to the interim manager on the second day of our inspection.

People were, at times, offered choices such as in relation to drinks and, at other times, staff placed drinks in front of people without asking their preference. On one day we observed a staff member asked people how much sauce they wanted and on another day plates were placed in front of people without a choice being given regarding portion size or whether sauce or custard, in the case of dessert, was desired.

We observed a staff member take a person's plate away as soon as the person had finished eating. The staff member did not speak with the person and did not ask whether the person wanted more. We then saw the staff member take another person's plate away, who had hardly eaten any of their meal, without exploring why or whether they wanted an alternative. This meant there was a risk the person's nutritional needs were not met.

We saw evidence of referrals to other healthcare professionals such as GPs and nurses. People had been offered flu jabs. One person told us, "They call the doctor if I'm poorly," and another person said, "They call the GP or district nurse if I need them."

Requires Improvement

Is the service caring?

Our findings

One person told us, "Staff are caring. They are really good with me. Night staff are lovely." Another person said, "Staff are very nice. I have a laugh with them. They [staff] don't get mad here. They're all nice." Another person told us, "Staff are nice and caring. They look after me, although I try and do as much as I can for myself."

A member of staff told us, "I enjoy working here. Staff get on well. We have a good bond with the residents. Residents are cared for." Another staff member said, "I enjoy my job very much. I enjoy working with elderly people. I like spending time with the residents."

People appeared comfortable in the presence of staff and we observed some interactions that were kind and caring in nature. However, our observations showed staff, at times, did not treat people with dignity and respect. A person's nurse call bell sounded and a member of care staff went to the person's room. We heard the member of staff say to the person, "You'll have to wait, we're [staff] still having our dinner." We asked the member of staff what the person had asked for and were told, "To go out for a cig. You can't say that's more important than us eating." All staff were sat eating lunch together at this point, leaving no care staff assisting people.

We observed a member of staff assisting a person to eat their breakfast. The staff member was gentle in their manner; however they did not attempt to communicate with the person. They spooned food into the person's mouth without speaking to the person, for the whole of the meal.

There was no staff interaction with people in the lounge area for the first hour when our observations began on the first day of our inspection. After the first hour, a member of staff sat on a chair in the lounge area and watched television, without speaking to the other seven people who were sat in the lounge at the time. There was a further 15 minutes with no interaction with people.

On multiple occasions we saw staff huddled together talking socially to each other. This meant there were many missed opportunities to engage with people living at the home.

We observed a member of staff move a person who was seated in their wheelchair, without speaking with the person. The person was moved from the lounge area towards the exit, with no communication.

We heard a person shout, 'Auntie,' as a member of staff walked in front of the person. The member of staff did not acknowledge the person or show they had heard them. However, the care worker then spoke with another member of staff quietly and staff then assisted the person to go to the toilet.

We observed staff assisting a person to stand, using a stand aid. Three staff were assisting the person and they spoke to each other, telling each other what to do, but they did not speak or communicate with the person they were assisting. No reassurance was given to the person, despite them showing signs of distress.

We observed, for a period of 15 minutes, three care staff were sat at a dining table writing records whilst a person was repeating a phrase and showing signs they were becoming anxious. Although staff were writing records, this was happening within earshot of the staff. No staff member broke off to offer assistance or reassurance. It was a member of domestic staff who spoke with the person and gave reassurance, when they entered the room.

Records showed a person was not given assistance with their continence needs until the evening on multiple occasions, despite this person having no control of their bladder. This meant the person was at risk of their dignity being compromised.

Staff were making decisions on behalf of people without consent and without assisting people to make their own decisions, such as by using advocates. We had raised this concern at the last inspection in November 2016 because there was risk some people's human rights were not being upheld and this had not been acted upon.

The above demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people were not always treated with dignity and respect.

We asked the interim manager whether end of life wishes were discussed. The interim manager told us they were aware this was important and this was an area of care planning they were hoping to develop, although there was no evidence this had begun.

We observed some examples of privacy being respected. For example, we saw staff knock on a person's door before entering their room. Confidentiality of private and personal information was considered and records were kept securely accordingly.

Consideration had been given to people's cultural needs and appropriate foods were offered. Some staff were able to converse with people in their preferred language. This helped to meet the diverse needs of people living at the home.

Requires Improvement

Is the service responsive?

Our findings

We asked people how they were kept occupied at the home. Comments included, "I sit in here all day. It's absolutely boring. I want to get out and about." We asked what activities were offered and were told by one person, "Nothing. I like doing exercises but not done any for a while."

The previous inspection found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care. We found at this inspection some care plans had been amended and updated and contained information to enable staff to provide person-centred care. Information in the new care plans contained detail relating to people's individual care needs such as communication, food, nutrition and mealtimes, skin, hygiene and personal appearance, mobility, medication and memory. The new plans contained some personalised information. For example one plan stated, 'I require assistance of one carer to assist me with washing and dressing. I can comb my own hair. I am able to choose my own clothes.' However, we noted this person's care plan indicated, 'Requires support with eating and drinking due to dementia diagnosis and reduced mobility,' but the plan did not include details so staff knew exactly how the person should be supported.

One of the care plans we inspected contained details in relation to the person's preferred language and another contained information relating to a person's specific cultural dietary needs. This showed that, for some people, important information was included in their care plan to enable person-centred care to be provided. One person's plan contained very specific information such as, 'I can wash my upper body and face if you pass me a flannel with soap on it. If you put toothpaste on my toothbrush and gesture what you would like me to do I will brush my own teeth.' Including this level of detail enables staff to provide care which is person-centred.

Eight people's care plans had been updated since the previous inspection. Four people's care plans had not been updated.

We asked a member of staff for the care plan for a particular person and we were given a plan dated October 2016. The member of staff confirmed this was the most up to date plan available for this person. This plan had not been updated since the last inspection in November 2016, despite concerns being raised at the last inspection regarding mental capacity and best interest decision making for this person.

At the previous inspection we were concerned a person who had been identified as high risk of falls did not have a moving and handling plan in place and there was information lacking in the person's care plan in relation to their mobility needs. We found this plan had not been updated since the last inspection and the interim manager confirmed this to be the case but added they were still working to update care plans.

We noted the care plans that had been updated since the last inspection showed no evidence people or their relatives had been involved in developing their plan, or reviewing their care needs. A person we spoke with, whose plan had been updated, confirmed they had not been involved in any reviews of their care plan. Furthermore, the 'my life history' section of three care plans we sampled had not yet been completed. We

raised this with the interim manager, who advised they were still working to develop these.

The previous inspection found a lack of person-centred activities and people told us they were bored. We found the same at this inspection. On the first day of the inspection we observed no activities taking place and very little conversation took place between people, although staff spoke to each other.

A member of staff told us there was no weekly plan of activities. They told us, "We choose a game on an afternoon for activity. Usually no more than three or four residents take part in activities."

Activities were recorded. However, records were incomplete and had not been updated since 4 March 2017. The most recent activities people had undertaken included, 'Drawing, watched TV, walked about the home, chatted to [name other another resident] and family visit.' Activities were not person-centred.

The above demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the registered provider had not carried out, collaboratively with relevant people, an assessment of the needs and preferences for people's care and treatment.

People told us they could make their own choices. One person told us, "I choose what I want to wear." Another said, "If I say, 'I don't like that,' they ask what else I would like. Staff give me choices," and a further person told us, "I go to bed around 5.30. It's my choice." We saw, at times, staff offered people choices and, at other times, people were no offered choices such as what they would like to drink or in relation to different components of meals for example.

At the last inspection in November 2016 we found a number of people's rooms appeared stark and did not contain any personal items. During this inspection we looked in five people's bedrooms and saw people had photographs and items of sentimental value on display.

We looked at how complaints were managed. The interim manager told us they were not aware any complaints had been made. A complaints policy was in place and at the last inspection we found the interim manager had implemented a log where complaints and resulting actions could be recorded.

The interim manager had introduced a daily communication log prior to the last inspection. Staff recorded relevant daily information regarding people's needs and the support provided. This enabled staff to share relevant information with each other in order to better provide effective care.

Inadequate

Is the service well-led?

Our findings

The registered manager had been absent from work due to maternity leave since March 2016 and had not returned to work at the time of this inspection. An interim manager had been appointed in November 2016 and they had been managing the home since then.

The Care Quality Commission was aware of some proposed changes to the business in terms of ownership. The home had previously been rated as 'Inadequate' and was, at the time of this inspection, registered with the same registered provider as the last inspection in November 2016. This inspection considered whether any improvements had been made since the previous inspection.

The registered provider was no longer involved in the day to day running of the home and we had been notified an agent had been appointed. The agent had employed the interim manager.

The previous inspection ratings were displayed. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities.

A member of staff told us, "The manager is fantastic to talk to. Very supportive." Another staff member said the interim manager was, "Approachable and very helpful."

The last inspection found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to governance and management oversight.

At this inspection we found weekly cleaning checks took place which considered whether rooms were odour free, curtains were opened, windows cleaned, bins were empty and wash basins and handles were clean. Other audits, however, such as pressure cushion and mattress audits were lacking. Since the beginning of the year, records showed pressure cushion audits had not taken place and only four mattresses had been checked in relation to their condition, despite 12 people living at the home.

The audits file contained monthly audit tools in relation to, for example, health and safety, kitchen, laundry, maintenance, medication and infection control. Audits for health and safety had been completed in December 2016 only. The monthly medication audit had been completed for January 2017 only and the infection control audit had been completed for December 2016 only.

The audits which had been completed, such as the maintenance audit for example, had failed to highlight concerns we found during our inspection. The medication audit that had been completed identified all written entries were not counter-signed. However, there was no indication of any action taken to address this. The medication audit failed to address the areas for improvement which were identified during our inspection. This showed the registered provider did not have effective audit and governance systems in place in order to assess, monitor and improve the quality and safety of the service.

We looked at 'Toilet charts.' These showed whether people were assisted with continence needs in the

morning, afternoon and evening. These records were incomplete. The records from 9 March 2017 to 11 March 2017 did not contain the name of one of the people residing at the home, so it was not possible to determine what assistance had been given in relation to their continence care on these dates. We showed this to a member of staff who said, "I must've copied it from the one before." Furthermore, records relating to activities were incomplete and not up to date. This demonstrated accurate records relating to people's care were not always kept.

We found a person's care record contained a blank mental capacity assessment tool but there was a detailed record of a decision being made in the person's best interest. However, the name of the person to whom this related was not the name of the person whose care plan we were reviewing. We asked a member of staff who the information related to and were told, "I haven't got a clue, but it doesn't relate to [Name of person whose care file we were reviewing.]" This further demonstrated accurate records relating to people's care and treatment were not always kept.

Our inspections in February and November 2016 found emergency plans were lacking. A file of emergency plans contained very little information. For example, there were no plans in place in the event of fire, flood, power cut, gas leak, equipment breaking down. We found the same at this inspection. This further demonstrated a lack of management oversight.

The above demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the quality and safety of services and the health and safety of people were not assessed and monitored, appropriate records were not kept and the registered provider did not evaluate and improve the quality and safety of the service.

The previous two inspections found concerns regarding a lack of staff support. The same was found at this inspection. Staff had not received regular supervision or appraisals of their performance. Staff training was not managed and delivered effectively and regular staff meetings did not take place. When we asked a member of staff whether they had any one to one supervision, they told us, "I go see my manager if I need to but I've not had any sit down supervision."

We previously found the registered provider did not seek and act on feedback from relevant persons. We saw a meetings planner with staff meetings listed once per month from January to June 2017. Residents' and relatives' meetings were listed as every two months. The interim manager advised no relatives attended the meetings in January or March 2017, so they were thinking of re-branding the meetings as, 'coffee afternoons.' However, this had not yet taken place. No residents meetings had taken place.

The interim manager confirmed a staff meeting took place in January 2017 but they were unable to locate the record of this during our inspection. The notes from this meeting were forwarded to us following the inspection. The February 2017 staff meeting had been cancelled. This meant that, although attempts had been made to introduce regular meetings, these had not been sustained. Meetings are an important part of a registered provider's responsibility to ensure information is disseminated to people and staff appropriately and to come to informed views about the service.

Since the last inspection in November 2016, a box with some relatives' questionnaires had been placed in reception. Only one questionnaire had been placed in the box so the interim manager told us they had sent some questionnaires to relatives in January 2017 in order to seek their views. This showed the interim manager was attempting to seek feedback from relatives of people living at the home.

The interim manager told us they were being supported and a compliance manager was visiting the home

approximately once per month, to assist with compliance issues.

We asked to see the policies and procedures for the home, including those relating to medicines and complaints. The interim manager told us the policies had been sent from one of the agent's other homes and they were in the process of adapting these to Blossom Care Home. Relevant policies were forwarded to us following the inspection.