Pear Tree Care Limited

Blossom House

Inspection report

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16 February 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The first day of inspection took place on 15 February 2018 and was unannounced. On 16 February 2018 two inspectors undertook an announced further day of inspection. The inspection was prompted in part by concerns raised by whistle-blowing notifications alleging concerns about people's care.

Blossom House provides accommodation and personal care for up to 31 people, the service does not provide nursing care. There were 28 people living at the home when we visited. The home had two floors with 19 ground floor bedrooms and five bedrooms on the first floor accessed by stairs and a stair lift. The ground floor comprised of seven double and 14 single bedrooms. There were communal areas on the ground floor and an accessible garden.

Blossom House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. We found the home to be clean and tidy throughout the inspection.

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.

Since 2015, all comprehensive inspections of the service had found regulatory breaches. The last comprehensive inspection of this service was in April 2016 when two regulatory breaches were found. The service was rated as Requires Improvement in Well Led and Good overall. In May 2017 we undertook a focused inspection to check on these breaches and found sufficient improvements had been made and there was no rating change.

At this comprehensive inspection we found five breaches of regulations. This was within nine months of the focused inspection in May 2017; this demonstrated that the provider of this service was unable to sustain improvement in the long term. There were systemic failings identified during this inspection which had already been identified at the last two comprehensive inspections of the service. All five regulatory breaches from the comprehensive inspection in January 2015 were repeated. Failures to provide safe care, treatment, person centred care, staff training, good governance and failing to act in accordance with the Mental Capacity Act 2005 were common themes. A further two breaches in respect of dignity and respect and premises were found.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Quality and safety monitoring systems were ineffective in identifying and directing the service to act upon and mitigate risks to people who used the service and ensure the quality of service provision.

Staffing was not planned effectively. There were not enough staff to meet more than people's basic personal care needs; staff were task orientated and did not spend one to one time with people.

Care plans were not consistently person centred and lacked detailed guidance for staff to ensure people received care in a safe way. Risk assessments that related to people's health and safety did not ensure that all risks were effectively assessed. Action had not always been taken to reduce identified risks to ensure the safety of people. This exposed people to a risk of neglect and unsafe or inappropriate care or treatment.

Records relating to the management of the service had not been effectively reviewed and assessed; we found errors, omissions and discrepancies that had not been identified by the registered manager's quality assurance systems.

The administration, safe management and security of medicines were in line with best practice. Topical creams had not always been recorded as applied and had not been audited to highlight this.

Records of the assessment of people's ability to make some informed decisions had been undertaken. However, records did not show that the principles of the Mental Capacity Act 2005 were being applied in respect of best interest decisions to provide care or use least restrictive practices. Staff we spoke with had a variable understanding of the Mental Capacity Act 2005.

Staff had not received adequate training to ensure people's needs were met. Staff had received regular supervision.

People had access to healthcare services. People were positive about meals and they were supported to eat and drink when required. However, records used to monitor peoples' fluid intake were not always completed with the correct intake; this had not been identified by reviews of records. This exposed people to the risk of dehydration.

Peoples' wellbeing was not promoted due to a lack of person centred activities. We observed, and people told us that activities were limited and did not take place as per the advertised schedule of activities.

People and relatives we were able to speak with said they felt safe. Staff said they knew how to prevent and report abuse.

We received some positive feedback about the care staff and their approach with people using the service; however, we observed occasions when people's dignity had been compromised.

People, their relatives and the external health professionals we spoke with were mostly positive about the service people received and people's visitors were welcomed.

There was a complaints policy in place. People and relatives knew how to raise concerns.

Appropriate recruitment procedures were in place and pre-employment checks were completed before staff started working with people.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response.

Services in special measures will be kept under review and, if we have not taken immediate action to

propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

We are currently considering our regulatory response to the breaches identified at this inspection. We will publish a supplementary report when our response has 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.

Staffing was not planned effectively.

Risk assessments that related to people's health and safety did not ensure that all risks were effectively and competently assessed. Action had not always been taken to reduce risks to ensure the safety of people.

Most medicines were managed safely but topical creams were not being recorded as required.

Staff knew how to report any concerns they may have in relation to people's safety.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People were being cared for by staff that had not received the appropriate training and checks on their competency before supporting them.

Where people lacked the ability to make decisions, such as those relating to care, best interest meetings or discussions had not been recorded. Staff had not received Mental Capacity Act 2005 training.

The environment was not suitable for people living with dementia.

People received a varied diet and were supported appropriately to eat.

People received effective healthcare and the service appropriately sought health advice and treatment effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for and treated with dignity, respect, kindness and compassion.

People who were able to speak with us and their relatives were positive about the way staff treated them.

People were supported to maintain valued relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans and care delivery was not consistently person centred.

People did not always receive adequate mental and physical stimulation or person centred activities.

People did not receive appropriate end of life care planning. End of life best practice was not clearly understood by the Registered Manager.

There was a complaints policy in place. People and relatives knew how to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

The service had a history of non-compliance and a number of these shortfalls had been repeated on past comprehensive inspections. These had been brought to the provider's attention on previous occasions. However, the provider had been unable to sustain any improvements in the long term.

The quality assurance process in place had not identified the areas of concerns we found.

There was little evidence of learning, reflective practice and service improvement.

The serviced worked in partnership with health colleagues to support people's health.	

Blossom House

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 commenced on 15 February 2018, was unannounced and undertaken 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 service. On 16 February 2018 two inspectors undertook a second day of announced inspection.

Before the inspection, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The inspection was prompted in part by receipt of a number of whistleblowing notifications. This information shared with CQC related to potential concerns about the management of risk of staffing levels, staff training, and the impact of this in managing identified risks safely. These concerns were reported to the local authority in December 2017 and this inspection examined those risks.

We spoke with eight people living at the home; other people were unable to have a coherent conversation due to their living with dementia. We also spoke with four relatives and with members of the management team including the registered manager, the head of care, and four care staff. We also spoke with two visiting healthcare professionals. We looked at care plans and associated records for six people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance. We observed care, support and activities being delivered in communal areas.

Inadequate

Is the service safe?

Our findings

People who were able to speak with us told us they felt safe. When asked if they felt safe one person told us, "Feel very safe here. Staff are very good and I'm well treated and supported by the staff." However, during the inspection we found areas of concern that could impact upon people's safety.

People living at the home were asked whether they felt there were enough staff. One person said, "All the staff are pretty good but not enough staff to support everyone." Another said, "I can't always get hold of staff at times and the home could do with more staff." A relative told us, "The home could do with more staff." Not all staff felt there were enough of them on duty at all times to meet people's needs. One member of staff said, "We need more staff we just haven't got the time to do everything". Another staff member said "I don't feel we have enough staff". All people at Blossom House had been routinely assessed upon joining the service as having high dependency levels to ensure there were appropriate staffing levels within the service. However, during the inspection we found that staffing levels did not evidence that people were provided with timely care and support from care staff.

The registered manager had not ensured that staffing was planned safely and effectively. We were told by the registered manager that the assessed level of night staffing was three comprising of one senior care staff and two care staff. We reviewed the rotas for the period 1 January 2018 – 23 February 2018. We found that 37 out of these 54 nights there were only two members of staff on duty. We saw that two newly recruited members of staff were put on a night shift together during January 2018. These were the only two members of staff working that night. This meant that the registered manager had little assurance of the competency of these two very new members of staff in supporting 28 residents with high care needs. This meant people were placed at risk due to being supported by staff that had not been assessed as competent and having the required training to meet their needs.

Due to some people living with dementia they were unable to use call bells to let staff know they needed assistance. For these people, risk assessments had been carried out and were managed by people being checked hourly when they were in their rooms and overnight. We asked the registered manager for records that these checks had taken place as required. The registered manager was unable to find any documented evidence of hourly checks during the night or continence pad changes as required. The head of care gave us an 'Event Report' for a person who had been assessed as needing hourly checks. This covered the period from 16 January 2018 to 16 February 2018. These contained one entry by staff for each night of this period, but these did not detail that hourly checks had taken place. This meant that we could not be certain that people who were unable to summon help had received the checks required to ensure they were safe. We asked one person how they would get help if they needed it. They said, "Well that's the point. How do I ask for help other than calling/screaming?" Following the inspection, the provider implemented systems and procedures to ensure that, where required, hourly checks by staff were undertaken and recorded.

Throughout the two days of the inspection, we reviewed how staff were deployed throughout the home to assist people. When we arrived on the first day of the inspection, one of the inspectors had been approached by a resident in the home to say someone had fallen in the living room. The inspector had to raise this with a

member of staff as there was no-one in the vicinity to assist. Throughout the two days we were undertaking the inspection, staff were frequently going outside for cigarette breaks. At times, this meant the communal areas were absent of any staff monitoring people's needs or interacting with them. On the second day of the inspection, a person had been given a cooked breakfast but after three hours they were still sat with unfinished food. This was not noticed until an inspector brought this to the attention of the registered manager. They offered to heat up the breakfast but as lunch was due to be served this would have been pointless. Also, the food such as a fried egg would be difficult to re-heat and retain the texture and taste as when it had been freshly cooked three hours previously. We were informed after the inspection that this person's preference was to have the food left with them. However, the registered manager did not assure us of this at the time. We also found the deployment of staff had not ensured that people were given the care and support they needed or to be responded to in the event of emergencies or incidents, such as choking.

We reviewed the staff training matrix which the registered manager provided on request on the first day of the inspection. The matrix detailed mandatory safety training areas. Not all staff had been recorded as receiving this training. Care staff were undertaking night shifts without training in all areas to ensure people were kept safe. For example, a staff member who had not been employed as care staff had completed regular night shifts on 19 occasions during January and February 2018. This member of staff had not received any training on safeguarding or medicines administration, prior to undertaking night shifts. Other members of staff completing night shifts had not received medication awareness or administration training. This meant that if people required 'as needed' medicines during the night that no member of staff had been deemed as competent to administer this safely. Following the inspection, we were sent an updated training matrix. This showed that training had been arranged post inspection. Out of 19 care staff, nine had been booked in for safeguarding training on 26 February 2018, 11 had been booked in for abuse awareness for 9 March 2018. However, we did not see that any training for medicines awareness or administration had been arranged for staff that had, and could potentially cover future night shifts. Abuse and safeguarding training had not been provided for all staff before they worked with minimum supervision, for example, during night shifts. This meant people were supported by staff that were not up to date in safety-related training. It also meant the registered manager was not certain that staff would be able to recognise potential signs of abuse and follow correct processes.

The failure to ensure people were supported by adequate number of staff with the appropriate training was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where risks had been identified and assessed we could not be sure people were receiving the care and support to monitor and manage these risks. This put people at risk of receiving unsafe and inappropriate care. We reviewed the care plan and risks assessments of a person who occupied an upstairs room. Their risk assessment stated the person could wander at night and they were unable to use the call bell due to their dementia. The risk management plan stated the person should have hourly checks throughout the night due to their inability to alert staff via a call bell. Earlier on in this section of the report, we explained that there were no clear records of whether these checks were taking place or not. This placed the person at increased risk if they were to come outside their room to look for staff. Following the inspection, the provider implemented systems and procedures to ensure that where required, hourly checks by staff were undertaken and recorded.

The risk assessment also stated the person used the stair lift to access their room. The risk assessment stated that a member of care staff was needed to safely support the person up the further three steps from the landing at the top of the staircase to their room. During the second day of the inspection, we saw the person walk down the stairs without using the stair lift following a care assistant. We noted that the person

stumbled towards the bottom of the stairs and was steadied by the member of care staff. This inconsistency for the person of not using the stair lift for all transfers up and down the stairs could pose future risks. This is because they may not always use the stair lift for this purpose. This risk was further heightened in respect of the absence of evidence of hourly checks overnight which meant the person could wander and fall down the stairs. We asked the registered manager if any technology such as door alarms or sensor mats were in use to help reduce risks. We were told that the home did have a supply of these but none were in use currently.

Safety concerns had not been consistently identified or addressed quickly enough. For example, there was a call bell event system which monitored staff response and times of these. We were informed that the system had not been working. The registered manager was unable to provide an exact timeframe for how long the system had been non-operational. We saw no evidence of this being pursued by the registered manager. This meant that monitoring staff response to people's request for assistance was not able to be effectively analysed so action could take place to address any concerns.

The adaption and design of the service had not been considered in line with people's needs. For example, there were only two toilets downstairs. One toilet was very small and would not have space for any walking aids. The other toilet was situated in the shower room. This meant if people needed to use the toilet they only had one option if someone was receiving care in the shower room. This meant there was a risk to the physical and emotional health of people in ensuring they could access essential facilities such as toilets. During our observations we noted one person becoming distressed when the toilet they tried to use was occupied by another person. This increased the risk of people being unable to manage their continence.

Where people had been prescribed creams to protect their skin, these had not always been recorded as having being applied by care staff. Auditing of topical creams was not included in the medicines audit. Therefore, this absence of recording had not been identified and action taken to ensure people received the creams they were prescribed to ensure skin integrity and comfort. We discussed this with the head of care who was confident that creams were being applied. We viewed stocks of creams and they did have evidence of being used and had opening dates on them which were recent. The head of care said they would immediately address the recording by staff of the application of creams and include this on the medicines audit.

The failure to identify, assess and monitor the risks in order to manage them safely; ensure that persons provide care have the competence, skills and experience to do so safely; and ensuring the proper and safe management of medicines was a breach of Regulation 12 Safe care and treatment of The Health and Social Care Act 2008 (Regulated Activities)

People had received their other medicines as prescribed. Medicines were stored securely and disposed of safely and accurate records of medicines were completed. Regular audits had taken place. Staff liaised effectively with agencies including GP's and pharmacies, and followed guidance with MCA, in respect of covert medicines.

The service managed the control and prevention of infection well. Appropriate personal protective equipment such as gloves and aprons were worn by staff. The premises were clean.

Staff told us that they would report any issues of concern to the registered manager and felt confident their concerns would be taken seriously. One staff member said, "I would raise any concerns first with my seniors and then with [registered manager]". Another staff member said "I would speak directly with [registered manager]. I am more than confident that something would be done". The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them.

There was a robust selection procedure for staff. Staff recruitment files showed that the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

Requires Improvement

Is the service effective?

Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. 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 made on their behalf must be in their best interests and as least restrictive as possible.

People were not always supported by staff that had been trained in the MCA. We looked at the training records for six staff members. Four of these staff members had not received training in MCA. Staff gave a varied response when describing how they applied the principles of the MCA to their work. For example one staff member said, "People may lack the capacity in one thing but not everything". Another staff member said, "It's when people can't make decisions, for some it's everything and some it just depends". A third staff member said, "Sorry I've never heard of it. Sorry". A fourth staff member said, "I can't remember what [MCA] is I think we did something on it once". The impact of this was the service had not ensured staff fully understood the requirements surrounding consent.

The registered manager did not always ensure that the principles of the MCA were applied when decisions made on people's behalf were conducted within a best interest framework. For example, one person's capacity was described by the registered manager as "fluctuating". This person had recently spent some time in hospital. Prior to the hospital admission the person had their own private room. However, on discharge from hospital the person was placed in a shared room with another person. We spoke with the registered manager about this and they told us, "People want to reside here but I can't always accommodate with single rooms". We asked the registered manager for evidence that this decision had been made in the persons best interest or if the person had given consent to be placed in a shared room. The registered manager confirmed no consent or best interest's procedure had been established. We spoke with this person and they told us "I wasn't asked. I suppose it's alright until something goes wrong".

There were a further 12 people in double occupancy shared rooms in Blossom House. We asked the registered manager to provide evidence of how consent had been sought from these 12 people. The registered manager was unable to provide this evidence and told us "There is no consent".

The requirements of DoLs were not fully understood as staff had received no training in respect of this. We looked at DoLs applications for six people and noted that the applications did not demonstrate that when applying for DoLs the service had considered and evidenced what the least restrictive options were to deprive people of their liberty. All six applications contained either the same or similar wording; this practice is not person centred. We spoke with the registered manager about this and they informed that the applications were carried out by an 'Administrator'. They told us, "Admin do it [DoLs applications]. I will get them to make them a bit fluffier". In the absence of a clear understanding of DoLs by the service we could not be assured that people's human rights were being protected.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014.

We asked staff if they felt supported by the registered manager and the provider. Most staff said they felt supported and they had access to one to one meetings with their line manager and yearly appraisals. However, the evidence obtained on the day of the inspection indicated they were not supported effectively. For example, one new member of staff had been placed on the staffing rota to cover a nightshift four days after they had commenced employment with the service. The same night shift was covered by another staff member who had started working with the service that day. Given the short period of time these staff member were employed by the service we could not be assured that they had received adequate training or had their competencies checked by either the registered manager of the provider. When this was raised with the registered manager and the provider we were informed that these staff members had existing qualifications. However, it is the responsibility of the provider to ensure that staff received the necessary training to meet the needs of the people using the service. A qualification obtained during previous employment does not negate the provider's responsibility to ensure training is up to date and that staff are competent before starting in their role.

Staff were not always adequately trained to carry out their roles and responsibilities. For example, we looked at four staff training records and noted that these staff members had not completed the provider's mandatory training in challenging behaviour, dementia, first aid, health and safety and person centred care. The training records for one of these staff members evidenced that they had not received manual handling training. The impact of this was that we could not be assured that staff held the correct skills, knowledge and competence required to carry out their roles and recognise poor practice. This meant that we could not be assured that people were receiving safe and effective care from staff.

During our inspection we noted that 13 members of staff had not received 'end of life' training despite caring for people who had been identified as being at the end of their life. Therefore, we could not be assured that the service had taken appropriate action to ensure that people approaching the end of their life were supported by staff that were confident or skilled to have meaningful discussions about people's wishes and preferences, including treatment options at the end of their lives.

Staff that had received training gave a varied response when describing the effectiveness of the training provided by the service. One member of staff told us "Yeah it's alright". Another staff member said, "Some of the training is alright but some is not practical enough".

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

There was limited effective signage in place to support people to be orientated. An effective signage system would have supported this person to access the only other available toilet on the ground floor. The main communal areas which people with dementia regularly occupied, including lounge and the dining room lacked items of interaction or stimulus which could be used to support reminiscence such as photo albums or books and items to interact with.

We noted that the only stair lift available for people was situated on a steep staircase with a narrow tread. Dependent on where the stair lift was left positioned meant reduction of space at either the top or bottom of the staircase. This meant people walking on the staircase could be placed at risk.

People's needs were assessed prior to their admission to ensure their individual care needs could be met in

line with current guidance and best practice. People's care records contained detailed information about their health care needs. For example, one person had been identified as having swallowing difficulties. A referral had been made to Speech and Language Therapy (SALT). This person was awaiting an assessment with SALT. We saw that this person was being supported appropriately by staff whilst awaiting their assessment.

The service worked closely with healthcare professionals such as, G.P's, occupational therapists, and district nurses to ensure that people received effective care. Where healthcare professionals provided advice about people's care this was incorporated into people's care plans and risk assessments. For example, one person's needs had changed in relation to pressure care. The service responded by making an immediate referral to the appropriate healthcare professionals. One visiting healthcare professional told us, "They phone us straight away if there are any problems". Another professional said, "I don't have any problems, [registered manager] is very reactive to our recommendations" and "They respond to our concerns".

People were offered a choice of meals three times a day from the menu. Staff advised us that if people did not like the choices available, an alternative would be provided. At lunchtime we observed that a person had changed their mind and asked for something different. Care staff responded to this and brought the person a meal of their choosing. We saw that people had choice whether to eat in the dining room, in the lounge or in their own rooms. A person we spoke with told us, "There's no problem with the food and you can always ask for more". A relative said, "Mum enjoys her food and she can get tea and biscuits throughout the day". Menus were displayed in the home's dining area and staff assisted people with their choices. During our observation of the lunchtime meal we noted that people were offered a choice of drinks. People had access to and were offered drinks throughout the day. Where people required special diets, for example, pureed or fortified meals, these were provided.

Risks around poor nutrition and hydration were managed effectively. People who were assessed as being at risk of malnutrition had accurate and up to date Malnutrition Universal Screening Tools (MUST) in place and were supported by staff that were aware of these risks and what action to take as a result. During our lunch time observation on the first day of the inspection we observed one person who was a risk of malnutrition being supported effectively by a staff member.

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind and respectful. One person said, "Staff are very good and we are well treated. I can call staff if I have any issues or concerns." Another person said, "All the staff are pretty good but not enough staff to support everyone."

However, during the inspection, we observed staff were focused on tasks and at times staff did not notice when people needed assistance. One person told us, "Could do with more staff company and support, no one ever seems to be around." At times, care staff seemed to be unaware of issues that could impact on people's experience in the communal areas. For example, there were two televisions on opposite walls in the lounge. We were told this was so that everyone had a chance to watch comfortably. We queried if the televisions were on different channels if this would be relaxing or enjoyable for people in the room. We were told the televisions were synchronised so that they would only ever be on one channel. However, at one point an inspector who was talking to the registered manager, noted that the two televisions were on different channels and found this very distracting. The registered manager did not respond to the conflicting television channels until prompted by the inspector. This meant that people may be subject to two competing television channels which would have been confusing and interfered with the enjoyment of programmes.

Throughout the two days of the inspection, we noted that the registered manager and many of the care staff took numerous cigarette breaks during the day. At times this meant there was no-one supporting anyone in the communal areas of the home. When care staff returned they had a strong smell of tobacco on their clothes. This meant that people received care by care staff that smelt of cigarette smoke. For people that experienced breathing difficulties or who did not like the strong smell this could prove unpleasant and potentially dangerous.

People's privacy, dignity and confidentiality had not always been evidenced due to a high number of shared rooms. This could impact on people should they be unwell or want some time alone. We also reported under the Effective domain of this report that where people did not have capacity to agree to share a room, this had not evidenced by a mental capacity assessment and best interest process to reflect their past preferences around privacy. Since the inspection, the provider submitted information that they were already proposing to eliminate as many shared rooms as possible. We also heard the provider has amended the financial pre-admission to reflect people's choices and decisions in relation to room type.

Staff described the practical steps they took to preserve people's dignity when providing personal care. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. Care staff explained how they always closed curtains, kept people covered as much as possible and told people what they were about to do. This would help ensure people's privacy and dignity during personal care. Where people shared rooms privacy screens were available meaning personal care could be provided in private. One person said when asked if they felt they were treated with respect and dignity from care staff, they said, "No problems what so ever."

People were offered choices and their decisions were respected. We observed staff telling people when it was lunch time and asking them where they would like to have their lunch. Some people living at the home had a diagnosis of dementia. This can affect their ability to make choices. We did not see any use of pictorial menu's to assist in choices of food.

Care files contained information about people's lives, preferences and what was important to them. For example, people's care plans contained information about their family and who was important to them. It also detailed former occupations and interests. However, we saw in one person's file very specific details about their former hobbies. However, there was no guidance about how this could be provided to allow them to continue to retain an interest or to reminisce of their enjoyment when they had been involved in the activity.

People were supported to maintain family and other important relationships. The home had an open door policy in respect of visiting and we saw a number of visitors to the home during the two days of the inspection. Relatives we spoke with said they could come and go when they liked and were quite happy with the support of the staff in welcoming them into the home and keeping them updated on their relative.

Where people had spiritual needs these were known and met. Care plans detailed any spiritual beliefs or needs a person may have and how they liked these to be met. The registered manager told us that they arranged for religious services to take place in the home.

Requires Improvement

Is the service responsive?

Our findings

People had not always received personalised care. Not all care plans contained person centred information. Care plans focused on healthcare tasks and not all evidenced that person centred information had been discussed and captured to ensure people received individualised care. The registered manager told us, "The care plans are aligned more to care needs." We raised this with the registered manager who showed us a new system that they were working on to capture person centred information. Although we saw that some steps had been taken to develop this system, it was not fully in place on the day of our inspection. When we asked a staff member to tell us information about a person's background and social needs and they told us, "I don't really know a lot about them, sorry". An effective person centred care plan would have supported this staff member to understand the person's social needs.

The home had a part time activities co-ordinator. We saw some examples of activities taking place. However, people were not always supported to be involved in social activities relevant to their individual preferences. For example on the first day and second day of our inspection we witnessed people being left unattended for long periods of time in the main communal lounge of the home with no or very little personalised engagement from staff. On one of these occasions a staff member entered the room and turned on the television without asking people or giving any choice in what they wanted to watch. A staff member told us, "We are understaffed we just don't have the time". Another staff member said, "Activities don't happen all the time. I don't think we do enough, we need someone here every day doing them".

Before we undertook the inspection, we received anonymous concerns that people were being left in wet pads for long periods of time. A member of staff had been dismissed as this allegation had been proved. The head of care said that checks did take place but as reported earlier we did not see evidence that these pad changes were documented. Therefore, the registered manager could not be certain that these were taking place as necessary. A relative commented to us that they had to request a pad change for their relative as it was wet and also had informed staff about a person who was sitting in a wet pad. Being left for long periods in urine soaked pads can cause skin to break down. It is also not affording people the dignity and respect they deserve.

We were informed at the time of our inspection there were two people receiving 'end of life' care. On the first day of our inspection we were shown one person's care records by the registered manager and they told us, "That's an end of life care plan so anything before that you don't need to worry about." We visited this person and they talked to us about their ongoing care needs. We asked the registered manager if this person was at end of life care or receiving palliative care due to an ongoing life threatening medical condition. We asked this because the guidance from the National Institute for Health and Clinical Excellence states 'End-of-life care is care occurring in the last part of a patient's life'. Whereas palliative care focuses on improving the quality of life and quality of care for patients with life-threatening or life-limiting [conditions]'. The registered manager informed us on the first day of the inspection that this person was receiving end of life care. However, on the second day of the inspection we were informed by the registered manger that the person was receiving palliative care. Due to the uncertainty of this person's stage of care we asked the registered manager if a review of their care had taken place. The registered manager told us, "No there

hasn't been yet". This is not in line with national guidance which highlights the need for end of life and palliative care needs to be reviewed appropriately. This meant that people at the end stages of their life may not receive care which ensures they have a pain free and dignified end to their life. Good end of life care should involve helping people live as well as possible and to die with dignity.

Both people were in shared rooms with people who were not receiving 'end of life' care. We asked a visiting healthcare professional, a senior member of staff and three staff members if they felt that this was appropriate and dignified and they told us, "No". We asked the registered manager if they felt this was appropriate and they said "No". We asked the registered manager to evidence the level of involvement that the person, those important to them and professionals had had in ensuring this practice was within the person's best interests and individualised to match their care needs. The registered manager informed us that, "Nothing formal" had taken place. There was no evidence and the registered manager confirmed that reasonable adjustments had not been considered to respect these people's current treatment needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The registered manager was unable to demonstrate, at the time of our inspection, that the provider had in place an equality and diversity policy. However, when we spoke with staff they were able to explain how they would protect the rights of people using the service. For example, one member of staff told us, "It's important we respect people as individuals no matter what their beliefs or individual needs are. It's our human right to be treated properly" and "If I thought someone was being treated unfairly then I would let everyone know and do something about it".

We asked the registered manager to provide evidence of how the service ensured it worked within the Accessible Information Standard (AIS) framework. 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 they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The registered manager was not aware of AIS. However, after we explained AIS they were able to demonstrate to us an example of where they had appropriately supported a person with poor eyesight to use an adapted telephone so they could keep in touch with relatives.

People knew how to make a complaint. We saw evidence that where people had complained, these complaints had been logged and responded to in line with the organisations policy. However, the registered manager was not always able to demonstrate how complaints had been used to make improvements within the service. For example, one complaint raised concerns surround aspects of people's personal care. Although this complaint had been dealt with accordingly there was no evidence that measures had been introduced to prevent reoccurrence.

Inadequate

Is the service well-led?

Our findings

Since 2015, all comprehensive inspections of the service had found regulatory breaches. The last comprehensive inspection of this service was in April 2016 when two regulatory breaches were found. In May 2017 a focused inspection to check on these breaches found sufficient improvements had been made. However, at this comprehensive inspection we found five breaches of the regulations. This was within nine months of the focused inspection in May 2017; this demonstrated that the provider of this service was unable to sustain improvement in the long term. There were systemic failings identified during this inspection which had already been identified at the last two comprehensive inspections of the service. All five regulatory breaches from the comprehensive inspection in January 2015 were repeated. Failures to provide safe and care and treatment, person centred care, staff training, good governance and failing to act in accordance with the Mental Capacity Act 2005 were common themes. A further two breaches in respect of dignity and respect and premises were found during this inspection.

This demonstrated that whilst in the short term the provider had been able to improve the service to meet standards, they had not been able to sustain this improvement in the long term. As at other inspections, a number of the shortfalls related to matters which had been brought to the provider's attention on previous occasions. These related to key aspects of the service, such as safe care and treatment, need for consent, staff training, person centred care, records and good governance.

During the inspection it was clear that on a number of occasions the registered manager was unaware of all of the responsibilities associated with their role; this also impacted on the ability of staff to know what good standards entailed as they were following the lead of the registered manager. For example, ensuring the principles of the Mental Capacity Act 2005 were being adhered to. The provider had secured the services of an external quality assurance assessor to ensure adequate oversight of the registered manager and the quality and safety of the service provision. However, they had not identified the concerns we found during the inspection.

A positive culture was not promoted by the registered manager to ensure the service was person centred and achieved good outcomes for people. The staff turnover was high with many existing, trained staff leaving and new staff not receiving the training and induction required. The registered manager had not always evidenced understanding of what was happening in the service. The registered manager had not role modelled positive behaviour such as ensuring staff did not take frequent cigarette breaks leaving people unsupported. This meant it could prove difficult to challenge this behaviour as the registered manager also took frequent cigarette breaks. This reflected a culture of staff needs coming before those of people in the service.

The provider had made lots of improvements in relation to the décor of the building. However, this type of improvement did not make the impact that was required to ensure the premises were 'dementia friendly' or improvements to improve people's privacy or ensure the environment was safe. For example, earlier in this report we explained about the lack of accessible toilets and access to the first floor of the home being via a staircase with a stair lift restricting the width. We also reported that people who were at the end of life were

in shared rooms without a contingency to potentially move them to a single room if they became very unwell or were at the end of their life. This meant despite the improvements to the décor and flooring, the building still did not meet the needs of the people supported there. The provider had plans and submitted evidence following the inspection demonstrating that they intend to carry out building works to alter the environment to better suit people's needs. However, this is yet to take place and we will need to ensure they are undertaken and the provider is able to sustain the improvements effectively.

There was not an effective system to identify, capture and manage organisational risks and issues. Records did not always contain enough information about people to protect them from the risk of unsafe care. Risk assessments were not always accurate, placing people at risk of not having all their needs met in a consistent and safe way. Governance was ineffective as there had been a failure to identify the concerns we identified. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment. We were told the registered manager did not specifically carry out unannounced visits out of office hours and said they monitored staff competence by working on shift alongside them. We discussed with the registered manager whether this would provide sufficient assurance that staff were carrying out their duties correctly.

The registered manager or other senior staff undertook audits of the service. These included audits of admissions, care planning, medicines, moving and handling and pressure care. These audits had not always identified where action needed to be taken, for example, ensuring that topical creams were included in the medicine audit and action taken where necessary. Another audit of turning charts had not identified that peoples repositioning had been appropriately recorded.

Following the inspection we requested that the provider submit an action plan in relation to the risks to people and concerns we identified during the inspection. We also asked them to review their admission strategy for the same reasons. The provider submitted an action plan which did not fully cover the areas of concern. We later received an updated action plan in response to our comments of the robustness of the action plan. The provider also agreed to voluntarily suspend any admissions to Blossom House.

The inspection history of the service has demonstrated that the provider is unable to sustain and improve the service to the standards required. The actions taken by the provider in response to this inspection provided some assurance that they were actively willing to make the improvements required.

The failure to provide good governance to ensure the safety and quality of service provision is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff we spoke with said they felt well supported by the registered manager. One member of staff said, "[Registered manager's name] is very helpful and supportive." Another said "[Registered manager] appraises us and tells us when we have done a good job". One member of felt staff morale had improved. However, a member of staff said that they didn't always feel heard and sometimes feedback was not acted upon.

The registered manager told us they also ensured the quality of the service provided by seeking the views of people about the service they received. We were provided with this information after the inspection. We saw that a survey was carried out by the service in December 2017. This was given to residents and relatives. We do not know how many people responded, but 95% were satisfied with the management, care and food. A small number (4%) fed back that they had not seen the complaints procedure. We saw two people had been sent a copy of the complaints procedure following this.

We spoke with two external health professionals who felt the registered manager alerted them appropriately

about people's health needs and followed their advice and guidance.

The organisation had policies and procedures for most areas of the service. However, the registered manager was unaware that there was an equality and diversity policy in place. The provider sent a copy of this policy to the Commission following the inspection. This policy pre-dated the inspection. We were told policies were reviewed yearly or when changes were required. We saw staff were requested to read these policies.

Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The registered manager understood their responsibilities in respect of this and was in the process of writing to a relative following an incident at the service. Family members were also kept informed verbally of minor incidents and changes in their relative's health.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in May 2017, was appropriately displayed at the home and on the provider's website.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.