Bluewater Care Homes Limited

Bluewater Care Home

Inspection report

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Date of inspection visit:
07 June 2022
05 July 2022

Date of publication:
13 October 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bluewater Nursing Home is a residential care home providing personal care to 15 people aged 65 and over at the time of the inspection. Some people were living with dementia. The service can support up to 60 people. Although it is called Bluewater Nursing Home, the home does not provide nursing care.

The home is based over four floors accessed by an interconnecting passenger lift. The ground floor provides communal areas for people and the first, second and third floors provide bedrooms, communal bathrooms and a small communal area. Only the lower two floors were in use at the time of the inspection.

People's experience of using this service and what we found
The provider continued to fail to ensure risks to people's health, safety and wellbeing were assessed and managed, which put people at increased risk of avoidable harm. Care provided was not always safe, in line with national guidance and risks were not always managed in the least restrictive way. There had been improvements in the management of health and safety, fire safety and other environmental risks identified at the last inspection.

There was evidence the provider had continued not to consistently and appropriately report and investigate incidents. The safeguarding authority had not always been informed of relevant incidents. There were not always enough suitably skilled and competent staff deployed to meet people's needs and manage risks to people's safety.

There had been some improvements in medicines management, however some issues remained. Staff had received a range of training. The provider was not able to demonstrate staff had been trained in specialist administration of one person's medicine which was to be given in the event of them choking.
The home was visibly clean. There were appropriate arrangements for visitors. The environment was spacious, we identified a need for further signs, in line with dementia friendly guidance, to support people to know where the toilets were.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's capacity to consent to decisions about their care was not always assessed, and it was not clear they had been provided with enough information to make an informed choice.

There had been improvements in managing people's nutrition and hydration needs. One person had gained weight, which was positive for them. Another person was being supported to lose weight, which was their goal. People were usually offered enough to drink but were not always given choices about what they wanted to drink.

Some people told us there was not enough to do, we observed some people were isolated and anxious and did not have enough occupation or emotional support. There were a range of activities available, however these were not always tailored to meet people's individual needs.

Although more audits had been completed, these were not sufficiently robust to assess and improve the quality and safety of the service. There were a number of continued breaches of regulations. Although some actions had been completed to address issues identified at the last inspection, not all issues identified had been addressed and people were still not receiving safe care. The required actions had also not been incorporated into a service improvement plan. New issues were identified at this inspection, demonstrating the provider was not pro-actively assessing their compliance with the regulations and working to improve in these areas.

Although the provider regularly engaged with other healthcare professionals, we were not assured their advice was consistently followed or clearly written into care plans. The local authority told us the provider had failed to attend large scale safeguarding enquiry meetings to review incidents which had taken place within the home, and had failed to provide an improvement plan when this was requested.

The provider was found to be defensive and not receptive to CQC 's feedback
Relatives gave mixed feedback, they felt they could raise concerns with the provider and these were usually resolved. One relative described the home as "OK, not the best", another said the staff "looked after [their relative] well". Other feedback included that "the environment is very unique" and "overall, I am happy with the care and support".

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

Rating at last inspection and update
The last rating for this service was inadequate (published 1 February 2022) and there were breaches of regulation. At this inspection we found the provider continued to be in breach of regulations.

This service has been in special measures since 19 May 2021.

Why we inspected
We carried out an unannounced inspection of this service between 25 March and 15 April 2021 and identified breaches of legal requirements. We undertook a follow-up, focussed inspection from 4 to 16 November 2021 to review if actions had been completed and if the breaches were met. We identified continued breaches of regulations in relation to consent; safe care and treatment; nutrition and hydration; good governance and fit and proper persons employed.

We carried out this inspection to follow up on these breaches of regulation and to understand if these were now met.

Enforcement and Recommendations
One breach has been resolved on this inspection, however we identified two new breaches of regulation and four ongoing breaches of regulation. We have identified breaches in relation to person-centred care, consent, safe care and treatment, good governance, staffing and fit and proper persons employed at this inspection.

Following this inspection we cancelled the provider's registration.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Bluewater Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors and a medicines inspector.

Service and service type
Bluewater Nursing Home is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Bluewater Nursing Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The provider informed us they had recruited a manager who had not yet commenced working at the service. The deputy manager had been acting up to manage the service and will be referred to in this report as "the acting manager".

Notice of inspection
The date of this inspection was unannounced. We requested a range of documentation prior to the site visit

to support our inspection process.

Inspection activity started on 25 May 2022 and ended on 5 July 2022. We visited the location on 7 June 2022 and provided feedback remotely on 5 July 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also reviewed information received from the provider and third parties since the last inspection, and other information received from the provider.

During the inspection
We spoke with the acting manager, the director and the head of care on the site visit. We spoke with six residents, two people's relatives on site and two people's relatives by telephone. We observed staff interactions with people through lunch time and through the afternoon.

We reviewed a range of records, including five people's care records, staff training records, medication records and other records related to the management of the service, including audits, policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At previous inspections, we found risks were not always appropriately assessed and managed, this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously, we identified issues in the assessment and management of risks including those related to people's eating and drinking, bowel management, skin integrity and falls risks.

At this inspection we found not enough improvement had been made and the provider remained in breach of this regulation.

Assessing risk, safety monitoring and management

● Risks to people's health, safety and wellbeing were not fully assessed and safely managed. Some risk assessments were not updated when people's needs had changed and there was not always clear guidance for staff on how to support people safely.

● During our inspection, we observed one person who had experienced recent falls and who was at high risk of falling. The person had a falls alarm, which notified staff when they stood up so staff could attend. During the inspection we observed they stood up, one member of staff attended and reminded them to use their frame, then the staff member left them. The person walked a few paces and went to sit in another chair. The chair slid and they nearly fell, but they managed to sit on the edge of the seat. We reviewed the person's care plan and risk assessments. The guidance for staff was unclear as different parts of their care plan gave different information about the level of support the person required. One section stated they needed supervision whilst mobilising. The person was not supervised while mobilising at the inspection. Another member of staff told us they would observe the person if they walked "too far".

● One person's moving and handling needs had changed two months prior to the inspection. Their falls risk assessments and moving and handling care plans had not been updated to reflect their increased falls risks and measures needed to help them transfer safely. The provider sent an updated version of their care plan during the inspection which had been amended to reflect this change, however the person had been supported for over two months by staff with no appropriate risk assessment and care plan in place to ensure their safety.

● We saw photographs of activities. In one photograph the person was being supported in a wheelchair on a trip out of the home, but there were not any footplates. This put them at risk of serious injury if their feet were to become trapped, as well as discomfort from this position. Another picture showed a person using a rollator frame, which is designed for indoor use, in the local park.

● People's pressure ulcer risks were assessed. One person's care record stated they required support or prompting to turn every three hours. The care records did not prompt staff to offer or turn the person overnight every three hours. Charts showed that most days staff recorded re-positioning overnight, however

there were occasions longer than three hours between entries. Some entries did not record the position, and some recorded the same position consecutively, meaning the person was not supported to re-position in line with their care plan.

● Another person's records showed they were not always re-positioned or supported to change position in line with their care plan, which stated every four hours. The person had variable ability to re-position themselves, sometimes they needed staff support. In the records, the person remained in the same position for extended periods of time on a number of occasions, in some cases for over 12 hours.

● Another person had been assessed as at very high risk of pressure ulcers. They had capacity, and had declined some specialist equipment, however their care records stated they "will give consent to the staff to be re positioned during the night, when [they feel] uncomfortable". There were no prompts or a schedule for staff to offer support to them to re-position regularly, or indication the person had declined all proactive support in this area. The person was not able to move themselves, however they were able to use a call bell to ask staff for support.

● One person was at risk of choking. They had been prescribed a modified diet in line with the International Dysphagia Diet Standardisation Initiative (IDDSI) level six, described as soft and bite-sized. On the last inspection we found they had been given foods outside of this level without appropriate professional guidance, risk assessment and care planning. At this inspection we found this issue had not been addressed. Records lacked details of foods given and their texture, or indicated foods which were not in line with the prescribed texture. Further professional guidance had not been obtained and the best interests meeting with their legal representatives did not include the foods which had been recorded as given, outside of the guidance for their prescribed texture such as wafer biscuits, pizza, pancakes, waffles, bread and butter or sandwiches. The care plan did not reflect the specific foods outside of the prescribed level which were being given, and how to manage giving these foods safely.

● After the inspection, the provider referred the person to speech and language therapy, however the referral was declined. The letter noted, "The referral states [person] is having a normal diet." And, "There is some ambiguity in the information provided."

Failure to appropriately assess and take action to mitigate risks to people's health and safety is an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had taken action in response to previous concerns related to the health and safety of the building, including removing obstacles from lift lobby areas, installing new window restrictors and residents had been moved from a room adjacent to the stairwell, with a risk assessment should any future residents be considered for this room. Regular checks had been completed related to fire risks.

Learning lessons when things go wrong

● We were not assured all incidents were appropriately recorded, reported and investigated, and that the provider took action to reduce the risk of re-occurrence. Although there was evidence some incidents were reported and acted upon, this was not consistent or robust.

● Not all falls recorded in people's risk assessments, were recorded in the falls logs or falls trend analysis sent to us by the provider. Some were documented in falls logs, but not reflected in people's risk assessments or care plans to demonstrate that these had been reviewed following the fall.

● One person expressed behaviours, including verbal abuse towards staff. There was no evidence incidents were captured, in line with their care plan, to support the identification of any triggers and how to best support the person. A member of staff told us the person had sworn at them "the other day". There were no events captured in the six months of records sent to us.

● One person's records included information about a "blister" on their thigh, this was not recorded on any incident, safeguarding or wound log. It was unclear what caused this injury and we saw no evidence this had

been investigated.

Failure to do all that is reasonably practical to mitigate risks to people's health and safety by reporting, investigating and learning from incidents is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

At the last inspection we found medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection, although some improvements were made, the provider remained in breach of this Regulation.

● Some aspects of medicines management which had been improved following the last inspection. The provider had changed pharmacy and had improved the information on topical medicines available to staff. Stock checks had improved, and storage temperatures were consistently recorded. Some gaps in records, such as missing protocols for 'as required' (PRN) medicines, or blank allergy sections on medicines administration records (MARs) had improved.
● There remained some issues and inconsistencies. One person's PRN protocol for constipation relief was not clear. Some protocols differed in the dose to be administered from the pharmacy label on the medication. One person's allergy information was blank on the MAR. One person on a blood thinner had a clear alert on their record, another on the same medication did not. One person had been on medication prescribed in hospital, and it was unclear if this medicine was to be continued by the GP. Another person had commenced a new medicine, and the administration instructions, including the frequency, were unclear.
● We reviewed bowel charts for people, and it was unclear whether PRN medicines for constipation were being given as needed. One person's MAR showed medication had been given on days not indicated by their bowel chart, and not on other days when it would be indicated. Another person's chart had recorded 'offered and not required' on days when their bowel chart would indicate they would require the medicine. Other medicines for that person recorded 'refused' for entries, so it was unclear staff had reviewed bowel charts and appropriately advised the person.
● Other aspects of medicines management and records required further improvement. Controlled drugs continued not to be stored in line with relevant legislation, as the cupboard had been modified. Balances in the controlled drugs register were not correct as they had not properly recorded returns of medicines to the pharmacy. This meant it appeared stock should be present when it was not. This was amended by the staff at the time. We found eight full sharps bins which were being stored, this was highlighted to staff who organised collection. A British National Formulary, which give information about medicines, was found which was out of date, this was disposed of.

Failure to ensure medicines were managed safely is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection the provider failed to undertake relevant pre-employment checks to ensure prospective staff were suitable to work with people. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we were not provided with records of staff recruited since the last inspection and the records we saw were incomplete. The provider therefore remains in breach of this regulation.

● We were sent two recruitment files; however these were staff who had been recruited prior to the last inspection.
● We reviewed one of the files seen on the last inspection and this continued to lack all of the relevant pre-employment checks, including evidence of conduct in relevant previous employment, and explanation of gaps in employment.
● One member of staff had been recruited since the last inspection, we were not sent this staff member's recruitment file during the inspection. This was sent after the inspection had concluded. The relevant pre-employment checks were made for this member of staff; however, aspects were not robust, including evidence of conduct in relevant previous employment roles.

Failure to undertake proper pre-employment checks and evidence that these checks were carried out is a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, we were concerned that there were not enough staff available to keep people safe on the first floor. During the afternoon, one member of staff was supporting the inspection process. For most of the time we observed there was one member of staff located on the first floor to support people and this staff member was going in and out of bedrooms and therefore not available to support people in communal areas. Whilst we acknowledge inspections can impact upon staff's availability, it is the provider's responsibility to ensure there are enough staff to meet people's needs and keep them safe.
● We observed one person who was visibly distressed and saying they did not know what to do with themselves. They were pacing and trying to interact with objects throughout the café area. Staff were not available to support them and did not identify the need for emotional support, distraction and occupation for this person over a two-hour period.
● Another person required support and supervision to ensure their safety when mobilising, according to their care plan, and we observed staff were not available, or were not able to prioritise supervising this person to ensure their safety.
● We reviewed staff rotas and staff training records. Rotas showed the provider did not ensure there was consistently sufficient staff deployed, particularly on night shifts, who were appropriately trained to meet people's needs. There were regularly no trained fire marshals, to support fire evacuation, or staff who were trained to administer medicines. People had prescribed 'as required' (PRN) medicines for pain relief, breathing difficulties and one person had a medication to be administered in the event of choking, this could be required at any time, including the night.
● One person had PRN medication which required specific administration. One person, the nominated individual, had been trained in this method of administration. There was no evidence all staff who may be required to administer this medicine had been trained to ensure this was done effectively and safely, if needed.
● We reviewed the dependency tool the provider used to understand staffing needs. People's individual assessments were not always accurate and up to date to reflect their current level of need, which would impact on indicated required staffing levels.

Failure to ensure enough suitably competent and skilled staff to meet people's care and treatment needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● We reviewed the incident and safeguarding logs sent by the provider, and the log of safeguarding referrals held by the local authority. We found there was a lack of consistency of reporting incidents to the local authority. Some unwitnessed falls resulting in injury had been reported, where others had not. We could not see a wound found on one person had been investigated to establish the cause, and whether this would be reportable.
● The local authority told us the provider had not attended large scale safeguarding enquiry meetings into incidents which had occurred at the service and had not engaged with the process. The provider disputes this feedback.
● Staff had completed safeguarding training and the provider had an appropriate policy in place. We saw relevant investigations had been carried out when required by the local authority.

Preventing and controlling infection
● The home was visibly clean. People had COVID-19 risk assessments in place, however there was out of date information regarding testing of residents and staff.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection we found that people's capacity to consent to decisions had not always been assessed, and that where capacity assessments had been completed these were not robust and didn't show how the decision had been made. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvements had been made and the provider remained in breach of this regulation.

- There were some improvements in the quality of MCA assessments where these had been completed, some had more information included to show how the assessment occurred and how the decision was made. Some still lacked detail, including how information had been provided in line with people's needs; what responses people had to the assessment questions; what the pros and cons were to the options discussed.
- One person still did not have an MCA assessment for the use of bed rails, which was identified at the last inspection. Another person had MCA assessments completed since the last inspection related to different decisions about their care, however in an updated version of their care plan we were sent, most of the

assessments had been removed from their care plan.
● Another person had recently had a significant change in their mental health, behaviour and disorientation which may have indicated they lacked capacity at times to make decisions. This had not been assessed.
● We identified the same issue as at the last inspection related to MCA assessments for taking photographs. The MCA assessments and best interest decisions considered consent to photographs for medical purposes and for leaflets and social media in the same document without differentiating. There was no evidence where people lacked capacity that it would be in their best interest for their photographs to be used for social media or promotional materials for the home.
● We were not assured risks were consistently managed in the least restrictive way and in people's best interests. The provider's CCTV policy stated cameras would "not infringe on living and circulating areas (corridors etc.)". However, we saw CCTV in corridors and communal living areas of the home. We requested and have not been sent a privacy impact assessment or risk assessment which identified the reasons for CCTV use and the alternatives considered. MCA assessments and best interest decisions still identified the reasons for CCTV as to protect people from "outsiders", which did not reflect the need for CCTV in corridors or living spaces.
● Codes continued not to be displayed in lifts for people to access communal areas downstairs without staff support where they could not retain the code. We observed one person, who was otherwise independently mobile, was not able to use the lift without staff because they could not retain the code.

Failure to assess people's capacity to consent and evidence decisions made for people were in their best interest is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection we found the provider had failed to work with or obtain timely treatment from relevant medical professionals, which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we found some improvements had been made, however the provider remained in breach of this regulation.

● We were not assured that the provider consistently sought advice and guidance, or followed the advice and guidance from relevant healthcare professionals to effectively manage people's health and wellbeing. One person's care plan and delivered care did not reflect the advice of the speech and language therapist, and another person's moving and handling information from a physiotherapist had not been reflected in their records in a timely way; as detailed in the Safe section of this report.
● The service participated in five-weekly multidisciplinary meetings, which included the GP and obtained support from relevant professionals, to raise any concerns and discuss people's health needs. We could see the service had discussed one person, whose behaviour had changed, to obtain a referral to mental health services. However, we could not see another person, who we were told had begun urinating inappropriately, had been discussed at this meeting.
● We noted people had access to chiropody services, their GP and other healthcare professionals. There was little information in people's records about how they could access the dentist, or when they had last seen a dentist, and most recorded they did not have regular dental appointments. However, we saw the manager had recently sent information to people's families about a change in how to access dentistry.

Failure to obtain and follow advice from healthcare professionals to manage risks to people's health, safety and wellbeing is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed. Some aspects of assessments and care plans were not in line with best practice or national standards. For example, one person had behaviour which may challenge staff. Their support plan used disrespectful language to describe the person, calling them "ignorant" and "rude", and it focussed on the impact of their behaviour on staff, not on how best to minimise and respond to triggers of their distress or anxiety.

● We observed some aspects of care which did not follow best practice related to the management of people's dementia. One person was displaying and communicating their anxiety and restlessness. They said, "I need to get some fresh air, I feel like I've been stuck in too much, it's killing me" and, "I don't know what to do with myself". They went to take the dish sponge from the sink and staff prevented them. They were stopped from assisting with tasks, such as wiping surfaces or tidying away, and they were left without occupation or interaction for long stretches of time.

● Another person indicated their boredom and we observed they were low in mood and isolated. They said, "[Staff are] very nice but there is nothing to do. I am stuck staring at these four walls. They're lovely but I am bored, I've got nothing to do. The TV is on all the time. I'm miserable, I want to go out somewhere, you're not allowed out without somebody with you." During our observations, we did not see staff interact with this person or offer them activities. Later in the afternoon the person came out of their room and asked staff where people were, the staff member indicated some people were doing activities downstairs. They said, "Nobody told me." The staff member offered to let them into the lift to go downstairs, they were otherwise independently mobile. This person did not have any authorised restrictions on their liberty and had not been assessed to lack capacity to choose where to live.

Failure to ensure the care and treatment of service users is appropriate and meets their needs and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Evidence-based assessment tools were used to understand people's risks and needs.

Staff support: induction, training, skills and experience

● Staff had access to a variety of online training and there were competency assessments for medicines administration for staff who carried out this task. We saw staff had structured inductions covering key topics. One relative said, "Staff are nice but not always that skilled."

● The staff training matrix reflected most staff were up to date with most training. One staff member was not included on the training matrix, we highlighted this to the provider who updated the records.

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

At the last inspection, we identified people were not consistently supported to eat and drink enough. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvements had been made and the provider was no longer in breach of this regulation.

● There had been some improvements in meeting people's nutrition and hydration needs. One person continued not to be offered two supplementary drinks consistently, however their weight had increased into a healthier range and records showed they were eating meals more regularly.
● The manager had identified one person had been declining their supplementary drinks in the afternoons in April and May, and had escalated this to relevant healthcare professionals in June. One person was trying to lose weight and was being supported to do so.
● People were mostly offered enough to drink, there remained some days where people were not offered enough to drink to meet their target intake, where they had been identified as at risk of dehydration. We saw people were given drinks throughout the inspection. During lunch there was only one type of squash available, and people were given hot drinks rather than offered choices.
● Most people appeared to enjoy the food at the inspection, one person who did not like the food was offered an alternative.

Adapting service, design, decoration to meet people's needs
● It would benefit people to have further signage from communal areas to the nearest toilet. On our inspection we observed one person who was unable to locate the toilet or their room. While there were no staff present, they entered another resident's room, causing them distress, trying to find the toilet. They went into another person's room and used their toilet and left water or urine on the floor. Another person, we had been told had been urinating on their bedroom floor at night. There was no sign on their ensuite bathroom door to identify it as a toilet.
● There were a number of clocks located around the building, but they did not have the correct time. Having the time displayed can help those with dementia to remain orientated to the time of day.
● The premises continue to provide a spacious environment for people, with communal areas and privacy for people in their rooms. There were items of interest displayed throughout the home. There were some dementia friendly signs, such as on the communal toilet door.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection, we found records were not always up to date, accurate and consistent. We identified audits and quality assurance arrangements in place were not sufficiently robust to identify and address issues otherwise identified on the inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, there had not been enough improvement and the provider remained in breach of this regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Oversight of quality and safety of the service was not robust. Issues we identified with risk assessments, care plans, delivered care, capacity assessments and staff deployed having relevant training were not identified in the audits. Not all issues from the previous inspection had been addressed, for example, people's risk assessments, MCA assessments, evidencing decision making related to CCTV use and lack of or inconsistent incident reporting and staff recruitment checks.
- There had been an increase in the numbers of audits carried out and evidenced. Some of these appeared to be isolated audits, rather than regular audits. Some actions from these audits had been completed, such as adding in a regular skin check for one person into the prompts for staff each day. Some actions identified had not yet been completed, such as acquiring clear glasses for mealtimes.
- Some audits did not appear accurate. For example, we saw food texture of lunchtime foods had been audited, however sometimes the named meal did not match the food chart for the person that day. There were also very high temperatures recorded for the foods after serving which would put people at risk from scalding. We identified it would be beneficial to assess what snacks were being served, or meals served outside of lunch as these were the times we identified one person was receiving foods which were not in line with their modified texture diet.
- There continued to be inconsistencies in records which could cause confusion or inconsistency in how people's risks were managed or their care was provided. It was difficult to obtain relevant records to review them for the inspection. The original document request was sent on 25 May 2022, some documents were sent shortly after the requested deadline on 1 June 2022, however not all were and the last documents were sent by the provider on 23 June 2022.

Failure to maintain accurate, up to date records and failure to assess and improve the quality and safety of services is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We continued to encounter a defensive approach by the provider, who disagreed with our findings. The provider had displayed the CQC report ratings, however "UNDER APPEAL" was written next to each of the ratings on the last inspection report, which is not correct. The ratings are not under appeal and the report has been published.

● We were not able to speak with staff beyond having conversations on site. We offered to speak with staff by telephone or email, within or out of their working hours. The provider advised us that staff did not wish to speak outside of their working hours, all but one member of staff declined to respond to our offer to speak.

● Staff were clearly caring in their approach and were working hard to meet people's needs. The deputy manager, Nominated Individual and provider were regularly present at the service throughout the week.

● The provider did not always promote a person-centred approach to care as people's individual needs were not always met. We saw evidence of a variety of activities including trips out of the home, nail painting and games, however, some people's needs around occupation and social isolation were not always met, this was based on feedback from people and our observations.

● Families told us they felt they could raise concerns with the provider. Comments of staff included they were "quite caring", that they "looked after their [relative] well". Another relative said their impression of staff was "positive" and they "seemed to know [relative] well."

● Of the home, one person's relative told us, "[Staff] are amazing, patient and kind but if it weren't for them, [loved one] would be in a very deep depression.". Other relatives said it was, "OK, not the best", "the environment is very unique" and "overall, I am happy with the care and support." Another said, "Their heart is in the right place, but the admin side of things is not great."

Continuous learning and improving care

● There was a service improvement plan in place. This included actions identified through walk rounds and audits. The service improvement plan did not include issues identified at the previous inspection to ensure they had been fully addressed, and some had not been addressed.

● There were some clear examples of escalation and learning from incidents, however not all incidents were appropriately reported and investigated so we could not be assured this was consistent.

● The provider continuously worked to maintain the décor of the environment to make it an enjoyable space for people. The service continued to have champion roles in place.

Working in partnership with others

● We received feedback from the local authority that the provider had failed to attend large scale safeguarding enquiry meetings held related to incidents at the home, and the provider had failed to provide an improvement action plan when this was requested. The provider disputes this feedback.

● The provider continued to engage with other healthcare professionals through the regular MDT meetings.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's relatives told us they could feedback on the service and were consulted appropriately on people's care plans. One relative did not know the registered manager had left earlier in the year.

● We saw there were relatives and residents' meetings, although we could not see issues raised at these meetings were always transferred to the service improvement plan, such as issues with people's clothes and laundry. This concern was also fed back to us by a relative, that her loved one "often looked untidy and sometimes was not in her own clothes".

● There were good links with the local community and the home was clearly involved in charity and community events.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We saw duty of candour letters had been sent to people or their relatives following recent incidents which resulted in serious injury, such as fractures. This included an apology and an outline of actions taken as a result.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's individual care needs were not being met.

The enforcement action we took:

Following this inspection we cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent was not appropriately and consistently assessed, people were not spported in the least restrictive way and in their best interests.

The enforcement action we took:

Following this inspection we cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not assessed and managed in a safe way, incidents were not reported and investigated robustly and consistently, medicines were not managed safely and guidance from healthcare professionals was not consistently sought or followed.

The enforcement action we took:

Following this inspection we cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight of the quality and safety of the service was not robust. Records were not always accurate or complete.

The enforcement action we took:

Following this inspection we cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed We were not assured the provider was undertaking required pre-employment checks of prospective staff to ensure they were suitable to work with people.

The enforcement action we took:

Following this inspection we cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough appropriately skilled and competent staff to keep people safe and meet their needs.

The enforcement action we took:

Following this inspection we cancelled the provider's registration.