Bluewater Care Homes Limited

Bluewater Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bluewater Care 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.

The home is based over 4 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 2 floors were in use at the time of the inspection.

People's experience of using this service and what we found
People continued to be at increased risk of harm as their risks were not consistently, robustly assessed and managed. Records showed care plans were not consistently followed related to managing people's safety, and this had not been appropriately acted upon by the provider. Incidents were not always reported or appropriately reflected in people's risk assessments or care plans, with identified actions of how risks would be managed or reduced in future.

Guidance and information from professionals was not always clearly captured in people's care plans. Where advice from professionals was unclear or conflicted, this was not escalated to ensure people's care was delivered safely.

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. Assessments of people's mental capacity were not consistently in place, or did not follow the code of practice to ensure people were able to make or participate in decisions about their care as much as possible.

Staff did not have appropriate pre-employment checks in place in line with requirements. This put people at risk of receiving care from staff who were not suitable to work with them.

There was no clear and credible plan in place at the time of the inspection to ensure past issues had been resolved and similar issues were prevented. Records were not consistently completed, or were not up to date, or contained inaccurate information. There was an improvement plan in place, however this reflected regular tasks which were required, not issues which needed to be addressed. After the inspection the registered manager sent a draft improvement plan which identified improvement actions needing completion, but this was not yet embedded.

The registered manager had failed to notify CQC of relevant incidents in line with regulations, and the current CQC rating of the service was not displayed on the provider's website.

There had been some improvements in medicines management, however some recording issues remained, including in monitoring people to ensure they received their medicines appropriately.

Staffing deployment had improved on our inspection site visit, and staff were more mindful of ensuring people in communal areas were not left unattended where they needed support should they wish to move. Some issues with staff training had been resolved, however we remained concerned about staff knowledge of modified food textures.

The home was visibly clean, and staff were wearing appropriate personal protective equipment (PPE). People were supported to have visitors to the home in line with current guidelines.

There was an improved culture amongst the staff team, and the registered manager and head of care were open and receptive to feedback. They took some immediate actions in response to issues we identified and showed they were open to making improvements.

Staff, people and relatives fed back positively about the staff and management team.

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 15 October 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 follow-up, focused inspections on 4 to 16 November 2021 and 7 June to 5 July 2022 to review if actions had been completed and if the breaches were met. On the last inspection we identified new or continued breaches of regulations in relation person-centred care, consent, safe care and treatment, good governance, staffing 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
We found 2 breaches had been resolved on this inspection, however we identified 2 new breaches of regulation and 4 ongoing breaches of regulation. At this inspection we identified breaches in relation to consent, safe care and treatment, good governance, display of ratings, notifications to CQC and fit and proper persons employed.

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

Follow up
We will request an action plan 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 service was previously rated inadequate and was placed in special measures. Though the overall rating had improved to requires improvement, there is still a rating of inadequate for one key question and remains in special measures. We will take action in line with our enforcement procedures. 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.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Bluewater Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 undertaken by 3 inspectors and a medicines inspector.

Service and service type
Bluewater Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Bluewater Care 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

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 used all this information to plan our inspection.

During the inspection
We spoke with 5 people living at the service about their experience. We spoke with 3 relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We made observations of staff interactions with people in communal areas and during a mealtime.

We reviewed 6 people's records associated with their care, various medicines records, training records and other records associated with the running of the service. We invited all staff who agreed to be contacted to speak with us if they wished to. We spoke with 6 staff, including the registered manager, head of care, chef and care staff.

We continued to liaise with the provider following the site visit to review records and give feedback on our findings.

Requires Improvement

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 has changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At the last inspection we identified a breach of regulation 12 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

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

● People's care plans and risk assessments continued to contain some inconsistencies, though improvements had been made in some areas. Care was not always provided in line with people's care plans or in a safe way. Monitoring charts demonstrated people's risks were not managed appropriately, and where records showed care was not delivered in line with care plans, this had not been identified, reported or investigated by the provider.
● Risk management plans did not always contain clear information from professionals involved in their care, such as information related to their prescribed equipment or management of risks to their skin integrity.
● During our inspection we observed 1 person sat in their chair with their legs on a low footstool with pressure relieving cushions in place. Their care plan stated that they should not use this footstool on the advice of an occupational therapist. The reasons were not stated in the care plan. A short time later we observed the person had slipped down over the edge of their chair and they were unable to get themselves back up. The head of care supported them with a second member of staff, and advised us that this was why the advice was given not to use the footstool, but that they had received conflicting advice from visiting nurses. We reviewed the communication with professionals and saw no evidence of conflicting advice, and saw evidence the agreed advice had been communicated between professionals.
● Some information, known by staff, was not reflected in people's care plans and risk assessments, which could result in information being lost, some staff not being aware of how to manage someone's risks, or decisions being made which did not take into account all the relevant information. For example, we were told 1 person had been removing the bumpers used to protect them from harm from their bed rails, but that using additional cushions had appeared to stop this, this information was not in the risk assessment or care plan.
● People were at increased risk of pressure ulcers as staff were not supporting them appropriately to re-position. We reviewed records for 2 people who required support and monitoring to re-position due to their risk of pressure ulcers. Monitoring charts showed re-positioning was not offered or carried out in line with

professional's guidance or their risks. Staff were not consistently recording re-positioning was offered, or it was not offered regularly enough. For some people, staff had not recorded how they had supported them to reposition and some showed they were not supported to change position, and remained in the same position for long stretches in the day or night. This issue was also identified on the last inspection. The registered manager told us they felt this was a recording issue, however, the issue had not been identified and investigated through governance.

● People at risk of choking were not supported to have appropriate foods in line with their requirements to reduce this risk. On the last inspection we identified people on modified texture diets, such as soft and bite-sized foods, were not receiving the appropriate textured food consistently. The service had identified 1 person who required a change to their food texture and had initiated a referral to speech and language therapists, which was positive, and there were 3 people who needed a modified at the time of the inspection. At this inspection we identified food charts for 2 people continued to record inappropriate foods recorded as given to people requiring modified textures, including as pizza, sandwiches, toast and pastry. Textures were not consistently recorded by staff and we were not assured staff understood how to prepare foods to the correct texture. The kitchen information did not identify that 1 person required a modified diet, and did not have any information displayed about the requirements or preferences of 1 resident. This has since been updated.

● We were not assured that people's medical conditions were well-managed. We reviewed 1 person, who had diabetes, had their blood sugars monitored by care staff and was supported daily by community nurses from the local NHS team. Concerns had been raised by the nurses related to the home's management of blood sugars. Blood sugar test results were not recorded by the staff with any required actions. We highlighted this to the head of care, who said they would ensure this is recorded on their care records system going forward. The care plan did not identify a blood sugar level which would indicate sugars were too high, requiring action. The head of care stated they would request the information from the nursing team and add this to the care plan.

● We were not assured people's risk of falling was appropriately assessed with robust management plans in place. People's falls risk assessments did not include accurate or detailed information about their past falls. For example, 1 person's risk assessment stated they had not had any falls since May 2021, however on our last inspection we identified they had fallen in April 2022. A new resident had an assessment, which identified they had a previous fall, but did not include any information about this in order to assess their ongoing risk or ensure there were appropriate measures in place.

● Updated environmental risk assessments had been completed. We identified the fire risk assessments did not include the storage of a person's electric wheelchair, where the battery poses a fire risk. This was highlighted to the registered manager who updated the document.

Failure to appropriately assess and manage risks to people's health and safety is a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had worked with other professionals to take action to implement more effective equipment in response to some fall's risks.

● Health and safety within the building was largely well-managed, most checks were completed as required, such as for fire safety, health and safety, legionella and equipment. The fire risk assessment was overdue by several months; we highlighted this to the provider, and this has since been booked.

● Some people's windows had broken hinge mechanisms, however this did not affect the opening gap or put people at risk.

Learning lessons when things go wrong

At the last inspection we found the provider had failed to appropriately report, investigate and take action in response to incidents. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Incidents were not always identified where they were a "near miss" or resulted in no harm. Information from incidents was not consistently reflected in care plans.
● When discussing 1 person's care, staff told us about incidents, such when they had damaged property or become physically aggressive towards staff, which were not reported as an incident or reflected in their care plan. In another incident, which was reported, the person had had hit another person, however this information was not reflected in their care plan with an appropriate assessment of their risk to themselves, other people living at the home or to staff.
● There was a lack of consistency in the recording of accidents, incidents and wounds, with incidents being recorded in different ways. Some wounds, which had wound care plans, were not reported as incidents to ensure they were appropriately reported, investigated and action taken.
● The registered manager had not conducted any thematic reviews or trend analysis of incidents. One person had multiple wounds, the head of care stated this was due to an allergy to their antibiotics, which they stated was known to the GP, but the medicines were necessary. No allergy to antibiotics was recorded on their medicine's administration chart.

Failure to do all that is reasonably practical to manage risks to people's health and safety by reporting, investigating and learning from incidents is a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●The head of care had recently implemented a new system to file incident records to provide a better overview of reporting and safeguarding.

Staffing and recruitment

At previous inspections we identified gaps in recruitment checks, this was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We reviewed 3 staff recruitment files, 2 were missing evidence of conduct in relevant previous employment working in health or social care, or with children.
● Reasons for leaving past roles were captured in recruitment files, however 1 member of staff's record stated they were "dismissed". There was no exploration of the reason, prior to them being offered or starting their employment. This was fed back to the registered manager who later confirmed this wording was an error and they had not been dismissed.
● One record was missing a staff member's full employment history back to education. We highlighted this to the registered manager who later told us the staff member declined to give this information and chose to leave their role.
● We asked if gaps in employment files identified on the last inspection had been resolved, and the manager was not able to confirm this.

Failure to undertake appropriate pre-employment checks is a continued breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff had Disclosure and Barring Service (DBS) checks in place prior to them commencing employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

At the last inspection we identified there was insufficient staff deployed to meet people's needs and keep them safe. Staff were not sufficiently trained to ensure people were safely supported. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● During out site visit, we found there were more staff present in the communal areas. Staff were aware of the need to hand over to colleagues should they need to leave the room. This ensured people were not left unattended in communal areas where they may be at risk of falling. Staff appeared less rushed and were spending more time with people.
● Dependency assessments were used to understand the staffing requirements to meet people's needs. These were largely reflective of people's current level of need, some minor inconsistencies were noted. Fewer staff were deployed at weekends than the staffing levels we observed on inspection. At weekends the registered manager, chef, administrator and cleaner were not on duty, and some weekend days when the nominated individual and head of care were also not rostered to support staff. The registered manager told us they had on-call support available if this is needed.
● More staff had completed medicines training, and the provider had ensured staff had completed specific training in administering emergency medicines to a person for their risk of choking. Night staff deployed were now trained in delivering medicines if needed.
● We reviewed Rotas for December, which showed there were multiple nights each week when no fire warden trained staff were on duty. This was also identified on the last inspection. However, the registered manager told us they had identified this and booked training for more staff to ensure there were always trained staff on duty, which has since been completed.

Using medicines safely

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

At this inspection some further improvements had been made and the provider was no longer in breach of this part of regulation 12.

● There had been continued improvement, particularly in staff understanding the purpose and management of medicines. People's medicines had been reviewed with healthcare professionals and changes made, such as reductions of sedating medicines and removal of multiple medicines for managing the same condition.
● Issues we identified which remained were similar to the last inspection. For example, controlled drug returns were not always recorded correctly. There were some 'as required' (PRN) protocols which lacked detail, such as whether the person was able to tell staff if they needed the medicine, or how staff should know what dose to give where this could vary.

● There remained issues in recording. For example, 2 people's allergy information did not reflect care records or reactions reported by staff. There was inconsistent recording of topical medicines. Some information had been captured in medicines administration charts, and other entries were made in care records, but the entries did not align.
● Some people were prescribed medicines if they became constipated and bowel charts were used to assist staff to identify when they needed their medicines. However, the charts were not consistently completed to enable effective management of constipation. During the inspection, we did not identify on review any instances of medicines not being given when required.

Systems and processes to safeguard people from the risk of abuse
● Staff we spoke with understood safeguarding, there was evidence the home was reporting concerns to the local authority.
● A number of concerns are open at present and are being investigated. The Local Authority was working with the home regularly to review this.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using personal protective equipment effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
● People were supported to have visits from their loved ones when they wished without restrictions.

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. At this inspection 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 previous inspections, we identified the provider had failed to ensure consent was obtained, or people's capacity to consent was properly assessed and best interest decisions documented. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider had not consistently ensured people's capacity to consent to decisions about their care was appropriately assessed, that decisions made were recorded, demonstrating these were in people's best interest in line with the MCA.
- There remained some gaps in undertaking mental capacity assessments, for example 1 person had a room sensor in place to manage their risk of falling – this impacted their privacy. They had previously removed a floor sensor which was used for the same purpose. The person had an impairment, which may

affect their capacity to consent which meant their capacity to consent should have been assessed. At the time of the inspection there was no assessment. This was highlighted to the registered manager who has since completed the assessment.

● Some MCA assessments were completed for multiple decisions in a single assessment at the same time. Capacity assessments should be undertaken at a time and in a way to create the best environment for the person. Assessing capacity and making multiple decisions at the same time may negatively impact those who have some level of capacity or fluctuating capacity to participate in the decision and express their views.

● Some records did not capture the decision which had been made and how this decision was arrived at, including options considered, pros and cons to those options and how that information had been provided to the person, or their representatives, to support them to make a decision.

● At the last inspection we identified issues with consent and capacity assessments related to photographs. We found consent forms, MCA assessments and best interest decisions considered consent to photographs for medical purposes, 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. This remained the case at this inspection and had not been addressed. This was highlighted to the manager who sent a new template for gaining consent for photographs after the inspection.

● At the last inspection we identified that some measures in place to manage risks were not appropriately assessed to ensure they balanced people's rights and freedoms with the risks posed. These issues had not been addressed.

● For example, at the last inspection we identified the CCTV policy for the home did not contain a privacy impact statement, and stated that cameras would not "infringe on living and circulating areas (corridors etc.)", despite the presence of cameras in these areas. We requested the updated CCTV policy, but this has not been provided to demonstrate this has been updated since the last inspection. CCTV continued to be used in communal areas of the home and we did not see any evidence that alternatives had been considered to have less impact on people's privacy, or that this had been appropriately considered in people's consent forms or capacity assessments and best interest decisions.

● In another example, at the last inspection we identified that codes for the lift were not displayed to allow any people living at the home who were otherwise independent to use the lift. At the last inspection the provider told us this was in a "welcome pack" for people, however this does not support those who are unable to retain the code to move freely in the home. At this inspection, the lift code was displayed, however this was disguised in pictures of fruit, and was not clear for people who may have visual impairment or dementia to independently access the lift. Use of key codes was reflected in people's capacity assessments, however this focussed on the person's ability to retain the code, not on the risk and benefits of locking access to communal areas of the home.

Failure to obtain consent, appropriately assess people's capacity and demonstrate decisions made were in people's best interest is a continued breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Some gaps identified on the last inspection had been addressed, for example 1 person now had a capacity assessment and best interest decision related to their bed rails.

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

At the last inspection we identified people did not always receive appropriate care which met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014

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

● People's needs were assessed. The provider used evidence-based tools to assess people's risks, such as their risk of malnutrition or pressure ulcers. These were regularly updated; however, assessments sometimes lacked the detail of risks and needs which were articulated by staff.
● Staff were responsive to people's emotional needs. We did not observe anyone becoming agitated or distressed on this inspection. Some incidents related to people's expression of their emotional reactions had been reported, however some incidents, such as someone damaging property, had not been captured. Staff were more aware of triggers which prompted people's reactions; however, this was not always well captured in people's assessments and support plans.
● We reviewed the support plan for a newer resident, they had assessments and a care plan in place, but these lacked some detail around their needs and preferences, such as food likes and dislikes. It did not yet give a clear guide of how to support this person.

Staff support: induction, training, skills and experience
● Staff had a range of training available. Staff said that they had opportunities to take part in further training if they requested it. The service has acted upon some gaps identified on the last inspection and further training which was booked or had recently taken place.
● Continued development was required for the senior care staff to allow for delegation of tasks and free up capacity for the head of care to provide more oversight of day-to-day care. We were told there was a plan in place for an additional head of care, who would receive additional training to support.
● We were not assured staff understood how to prepare foods in line with people's required texture diet in order to safely manage their choking risk. Staff had received some training in up to date preparation of food textures, however we were not assured this was applied in practice or fully understood by staff. The head of care stated they were organising additional training.

Supporting people to eat and drink enough to maintain a balanced diet
● People whose fluid intake was being monitored showed they were usually offered enough to drink; this had improved since the last inspection. There were occasional days where not enough fluid was recorded as being offered. The head of care stated this was a recording issue and was confident the staff were offering enough to drink. We observed 1 person's target fluid intake was unclear in their record, however others were clear. We observed staff offering drinks to people regularly and ensuring they had them within reach.
● The mealtime observed in the dining room was calm and well managed. People appeared to enjoy their food, and they told us the food was good. Staff offered more choices to people than on the last inspection.
● We observed staff support people to eat. Their interactions with people were positive; staff were patient and sat next to people.
● There was a lack of up to date information on some people's dietary requirements displayed in the kitchen - 1 resident's name and information was missing, another did not specify they required a modified texture, and another specified they were vegetarian, where their care plan identified they "liked fish". We highlighted this to the registered manager and head of care. We were told people would always be offered the full choice and would not be denied their choice if they were, for example, vegetarian and wanted to have a meat or fish option. We were told the information in the kitchen had been updated following the inspection.
● The provider had identified people's risks related to their nutrition and escalated their needs where appropriate.

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

● People had received support from professionals, such as occupational therapists or community nurses. Some advice from professionals was unclear or absent from records, or, where the service said advice had been contradictory or unclear, this had not been escalated to ensure the most appropriate guidance was in place. Following the inspection, the service told us they put in "communication books" to allow visiting professionals to quickly handover key information.

● There were regular multidisciplinary team meetings with healthcare professionals supporting the home discussing people's care which the service attended. Professionals fed back that they were not yet confident that the home was pro-actively identifying people who required review by the multidisciplinary team, and they were undertaking proactive reviews of people's needs to ensure these were met.

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

● There were no significant changes to the home décor of communal spaces or layout since the last inspection.

● On the last inspection we identified 1 person, who had been unable to use their en suite toilet appropriately at night, at this inspection they still did not have a sign on their toilet door. This was immediately addressed by the head of care.

● We did not see evidence that additional signage to toilets from communal areas had been acted upon, as identified in the last inspection. However, we did not see any people enter other people's rooms inappropriately on this inspection, as they were not left unsupervised by staff in communal areas.

● We noted clocks were not set to the correct time or were not working, as identified on the last inspection. Having clocks, visual calendars and other visual prompts for the time of day and time of year helps people with dementia to remain orientated.

● On a previous inspection, we identified 1 bedroom had access to a stairwell, this remained unoccupied and so did not pose a risk at this inspection.

● People's bedrooms were being re-decorated in line with their preferences of colour and items of interest which had been well-received by the residents and their families. The home had invited members of the public to donate items to a resident to help decorate 1 person's room related to their favourite football team.

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. At this inspection the rating 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At previous inspections we identified audits and quality assurance measures were not sufficiently robust, and records were not always up to date, accurate and consistent. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Though some improvements were noted, particularly in approach of staff and the openness with inspectors, there remained significant concerns, many of which were unresolved from previous inspections. There was limited evidence of audits or robust oversight of the quality of care in the home, or examples of where issues had been proactively identified by the provider and addressed, rather than identified by external professionals.
● Some actions from previous inspections had been addressed, however some issues, including issues involving the same individuals, had not yet been addressed. There was no clear plan of how issues and learning from past inspection was being addressed. Continued breaches were identified related to regulations consent, safe care and treatment and fit and proper persons employed, as well as new breaches of regulation identified at this inspection. We asked for examples where the registered manager had reviewed care and identified an issue to resolve, with what actions they had taken, however they were unable to identify improvements they had identified internally.
● There remained issues with record keeping, including people's care plans, risk assessments, monitoring charts and medicines records. Records did not evidence care was delivered in line with care plans, and there was no evidence that errors in recording were identified or were being addressed. There was a lack of oversight of care records and scrutiny of where issues had been highlighted in the past.
● Examples included people's re-positioning charts, eating and drinking charts, bowel charts, incident reporting and communication with professionals. Some care plans retained inconsistencies or lacked detail from professional guidance. The registered manager and head of care had identified some issues; however, this had not been formalised or documented and incorporated into an audit or quality improvement plan.
● The registered manager sent us an improvement plan which was in place, however this largely reflected

regular tasks required, such as running payroll or doing monthly tasks, rather than improvements required. Following the site visit, the registered manager sent a new, partially completed, improvement plan which they said they were drafting with support of a consultant.
● The registered manager had been in post for approximately 4 months at the time of the site visit. They had identified the audits in place were overly lengthy and created duplication, and so planned to address this. Following the inspection, the registered manager sent us a range of blank audit templates they planned to use, which appeared appropriate and covered areas identified in this inspection, however these had not yet been put into use and embedded.

Failure to ensure records are accurate, up to date and complete, and failure to robustly assess and improve the quality of the service is a continued breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Providers are required by law to submit notifications to CQC to inform us when important events or serious incidents took place at the service. The registered manager had not submitted notifications to CQC related to allegations of abuse or neglect which had been reported to the local authority.

Failure to notify CQC of relevant notifications is a breach of regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009

● We requested notifications be completed in retrospect in line with the regulations. Most concerns raised to the local authority have now been notified.

● We identified that the CQC rating of the home had not been displayed on the provider's website.

Failure to display the received rating of a provider's location on its website is a breach of regulation 20A (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We highlighted the absence of the rating to the registered manager who addressed this.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff were positive about the management structure in place. Staff were positive about their team-working. A member of staff said, "It's the best place I've worked." Relatives we spoke with were generally happy with the care. A relative told us, "There is always something going on…[Relative] loves it."
● The culture and atmosphere in the home was improved since the last inspection, with a more open approach to sharing information with inspectors. The registered manager and head of care were receptive to feedback, and some actions were immediately addressed when we identified them.
● Some concerns remain around the understanding of the importance and risks involved with some aspects of care.

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 did not see any examples of the provider acting on their duty of candour, however the registered manager understood their responsibility to be open and honest.

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

● There were meetings with residents to gain their views, we saw notes from meetings in October 2022, and surveys sent out to people and relatives to gain feedback, such as any activities they would like or feedback on the food in November 2022.
● Families told us they felt they could raise concerns if they needed to and these would be responded to. A comments book was provided for visiting families and professionals to give feedback. We saw comments such as, "Staff are very friendly and helpful", "[Staff member] is lovely and very helpful" and "Staff friendly".

Working in partnership with others
● We received mixed feedback from other agencies regarding the home, professionals reflected that staff were helpful, however there remained some concerns over practice which were being addressed through safeguarding concerns.
● Some meetings with stakeholders were regularly attended by the registered manager, where others had been more sporadic. The registered manager told us they had missed 2 meetings with the local authority; however, these had been re-scheduled.