

# Bluebell Nottingham Ltd

# Bluebell Lodge

## Inspection report

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## Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service effective?	Inadequate ●
Is the service caring?	Inadequate ●
Is the service responsive?	Inadequate ●
Is the service well-led?	Inadequate ●

# Summary of findings

## Overall summary

We conducted an unannounced inspection at Bluebell Lodge on 11, 12 and 17 December 2019. Bluebell Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This was the second time we had inspected this service since it was registered in 2016.

Bluebell Lodge is situated in Skegby, Nottinghamshire and is operated by Bluebell Nottingham Limited. The service accommodates up to 36 people. At the time of our inspection there were 28 people living at the home, all were older people and some were living with dementia.

At our last inspection in March 2018 the service was rated Requires Improvement. Three breaches of the legal requirements were found, there were in relation to safe care and treatment, staffing and dignity and respect. At this inspection we found the quality and safety of the service had deteriorated. Consequently, we found concerns across areas including safety, medicines management, staffing, consent, person centred care and leadership and governance. This resulted in several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. This was the first time the service had been rated as Inadequate.

There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Throughout our inspection of Bluebell Lodge, we found serious concerns that posed a risk to the safety of people living at the home. People were at risk of harm as risks associated with their care and support were not managed safely. Risk such as falls, choking and pressure ulcers were not properly assessed and there were insufficient measures in place to reduce risk. People were at risk of injury due to poor moving and handling practices. People were unable to summon help as their call bells were not always left within reach. We found multiple concerns with the management and administration of medicines which placed people at risks of not receiving their medicines as prescribed. People were not protected from environmental risks. The home was not clean and infection control practices were not followed. People were not protected from abuse and improper treatment. Safeguarding referrals had not been made when allegations had been raised against staff and people were subject to restrictive behaviour management techniques. There were not enough staff to meet people's needs and people were supported by staff who did not have the competency to ensure their wellbeing or safety. Safe recruitment practices were followed.

People were not offered enough to eat and drink and were at risk of dehydration or malnutrition. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this

practice. People were deprived of their liberty without the necessary authorisations. Care and support was not properly planned and coordinated when people moved between services. People's health needs were not met and their needs were not reassessed when their health changed. Care was not always delivered in line with current legislation and standards. People were supported by staff who did not have the required skills or competency to provide safe and effective support. The environment did not fully accommodate people's physical needs and the needs of people living with dementia and/or memory loss had not been fully considered.

People did not receive consistently kind and caring support. There was an inconsistent approach to involving people in decisions about their care and support. People's right to privacy was not always respected. Staff did not always recognise when people needed support. Staff routines took priority over person centred care.

People were not provided with adequate levels of basic care. Care plans were contradictory and did not reflect people's needs, some people did not have care plans in place at all. This meant there was no information about what mattered to these people or how best to support them. Staff knowledge of care and support was variable and people did not always receive safe support that met their needs. People's end of life needs and wishes were not planned for. The care and support provided at Bluebell Lodge did not reflect people's preferences. People's social needs were not met, many people spent long periods of time unoccupied, there was little attempt to interact with people socially or provide the opportunity for meaningful occupation. There was a risk people's diverse needs may not be met. Appropriate action was not always taken in response to complaints.

There had been a failure to identify and address serious issues with the safety and quality of the service at Bluebell Lodge. Systems to monitor and improve the quality of the service were not effective. Where audits had identified areas for improvement action had not been taken to address issues. We had concerns about the competency of the leadership team. Effective action was not taken to address concerns raised during our inspection. The implementation of improvement plans was disorganized and there was a lack of effective oversight of planned action. Failings in leadership and governance placed people at risk of harm.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Inadequate ●

The service was not safe.

People were at risk of harm as risks associated with their care and support and the environment were not managed safely. Medicines were not managed and administered safely. Opportunities to learn from accidents and incidents had been missed. There were not enough staff to meet people's needs. People were not always protected from the risk of abuse and improper treatment. The home was not clean and people were not protected from the risk of infection. Safe recruitment practices were followed.

### Is the service effective?

Inadequate ●

The service was not effective.

People were not offered enough to eat and drink and were at risk of dehydration or malnutrition. People's rights under the Mental Capacity Act 2005 were not protected. People were deprived of their liberty without the necessary authorisation. Care and support was not properly planned and coordinated when people moved between services. People's health needs were not met. Care was not always delivered in line with current legislation and standards. People were supported by staff who did not have the required skills or competency to provide safe and effective support.

### Is the service caring?

Inadequate ●

The service was not always caring.

People did not receive consistently kind and caring support. There was an inconsistent approach to involving people in decisions about their care and support. People's right to privacy was not always respected. Staff did not always recognise when people needed support. Staff routines took priority over person centred care and people's preferences.

### Is the service responsive?

Inadequate ●

The service was not responsive.

People were not provided with adequate levels of personal care. People were at risk of receiving unsafe support that did not meet their needs. People's end of life needs and wishes were not planned for. The care and support provided at Bluebell Lodge did not reflect people's preferences. There was a risk people's diverse needs may not be met. Appropriate action was not always taken in response to complaints.

### Is the service well-led?

Inadequate ●

The service was not well led.

There had been a failure to act on the concerns resulting from our last inspection. Systems to monitor and improve the quality of the service were not robust. Where audits had identified areas for improvement swift action had not been taken to address issues. Effective action was not taken to address concerns raised during our inspection. We had concerns about the competency of the leadership team. The implementation of improvement plans was disorganised and there was a lack of effective oversight of planned action. Failings in leadership and governance placed people at risk of harm.

# Bluebell Lodge

## Detailed findings

### Background to this inspection

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

This unannounced inspection took place on 11, 12 and 17 December 2018. The inspection team consisted of two inspectors, an inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection visit, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit, we spoke with eight people who used the service and the relatives or friends of three people. We spoke with five members of care staff and the activities coordinator. In addition, we spoke with the following members of the management team; the registered manager, two directors and the Nominated Individual. The nominated individual is a person who is nominated by the provider to represent the organisation.

To help us assess how people's care needs were being met we reviewed all or part of 15 people's care records and other information, for example their risk assessments. We looked at people's medicines records, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

As this was a responsive inspection we did not ask the provider to complete a 'Provider Information Return' prior to our inspection. This is information we require providers to send us to give some key information

about the service, what the service does well and improvements they plan to make. We gave the registered manager the opportunity to share this information with us throughout the inspection.



# Is the service safe?

## Our findings

At our last inspection in March 2018 we found people were not protected from risks associated with their care and support. This was a breach of the legal regulations. At this inspection, we found, new and ongoing, serious concerns that posed a risk to the safety of people living at the home.

People were at risk of injury due to poor moving and handling practices. Throughout our inspection, we observed people being drag lifted. Drag lifting is where staff place an arm or hand under the person's arm pit to lift them. Drag lifting should never be done as can result in serious injury. For example, we observed a very poor underarm lifting technique by two staff when a person was moved from their wheelchair to a sofa. The person was visibly distressed by the process. We observed other people being pulled up by their clothing or hands and wrists. These were not safe techniques. Poor moving and handling practices placed people at risk of injury.

Measures in place to reduce risks were not always implemented effectively. For example, one person's care plan stated they were to be checked every 15 minutes to ensure their wellbeing. However, a recent incident record documented they had been 'missing' for a period of six hours. The person was found locked in a room surrounded by broken glass. There was a record of 15-minute checks completed for this period which stated the person was 'assumed asleep'. The failure to identify that the person was not in their bedroom demonstrated 15-minute checks were not completed as required.

People were at risk of harm due to a failure to effectively assess risks. An incident record documented one person was found on the floor by the side of their bed having climbed over their bed rails. Luckily, the person did not suffer any injuries. A bed rail risk assessment did not address the risk of the person climbing over the bed rails and consequently opportunities to prevent this risk had been missed.

People were at risk of developing pressure ulcers. Repositioning charts did not evidence people were repositioned as required. One person had a pressure ulcer and required two hourly repositioning to prevent it from worsening. However, records did not demonstrate they were repositioned in line with this guidance. There were gaps of up to 14 hours between repositioning. This was also a concern for three other people. This failure to regularly reposition people placed them at risk of developing pressure ulcers or deterioration of existing pressure ulcers.

People were not protected from the risk of falls. An incident record documented that a person had had sustained a fall resulting in injury that required emergency treatment. Staff told us and we observed there were no additional measures, such as sensor equipment or enhanced checking, put in place following the fall to prevent it happening again. Consequently, the person fell again 13 hours later sustaining further injury. This failure to act to reduce the risk of falls resulted in the person sustaining actual harm.

Systems to review and learn from accidents and incidents were not effective. Consequently, opportunities to reduce risks to people had been missed. The registered manager told us there was no one who fell frequently at the home. However, falls records showed this was not the case. One person had fallen eight

times in the past six months. They had sustained some minor injuries because of these falls such as cuts and bruises. Several of these falls were unwitnessed at night time. Although there were falls audits in place they had not identified this trend and there were no measures in place to reduce the risk to the person. This placed people at risk of harm.

People were unable to summon help as call bells were not always left within their reach. We observed two people were left in their bedrooms without access to their call bells for over four hours. Staff attended to their personal care needs in this period but did not ensure their call bells were accessible to them. This was a particular risk for one person who was unable to get out of bed without support, their bedroom door was left closed and the door to the main corridor was also closed so staff could not hear them call for help were they to do so. The failure to ensure people had access to call bells placed them at risk of harm.

People's behaviours were not managed safely. One person was known to behave in a way that placed others at risk. Incident records documented several incidents of verbal and physical aggression towards others. Despite this there was a lack of personalised information about this in their care plan and no risk assessment. Behaviour charts documenting verbal and physical aggression towards staff and others had not been reviewed and their care plan was not updated to reflect learning from incidents. This meant opportunities to improve support and reduce risk may have been missed.

People were at risk of not receiving their medicines as prescribed. We found multiple concerns with the management and administration of medicines. Records did not always evidence people were given their medicines as prescribed. We found missing signatures across the majority of the medicines administration records (MAR) we viewed which meant we were unable to tell if people had been given their medicines. A failure to give medicines as prescribed could have had a negative impact on people's health and wellbeing. One person was prescribed a skin patch for pain relief, to be applied every 72 hours. However, records showed inconsistencies in patch replacement. Consequently, there was between 48 and 96 hours between replacements of the patch. This placed the person at risk of experiencing unnecessary pain and discomfort. Medicines records showed several people had not been given their medicines as they were asleep. For example, one person had missed their evening medicines for three days in a row as they were asleep. There was no evidence that this had been reviewed to consider alternative approaches.

There was a risk people may not receive 'as required' medicines when needed. There were no protocols in place related to the administration of 'as required' medicines. One person was prescribed a medicine to be given 'as required' to manage pain. There was no protocol in place to guide staff on when this medicine should be given and the person was unable to request this medicine. This meant people may not receive 'as required' medicines and placed them at risk of suffering unnecessary pain, distress or discomfort.

There was a risk people may not receive medicines through the night if required. The registered manager told us and records confirmed that night staff did not have up to date training in the safe administration of medicines. There were several people who were prescribed 'as required' medicines, for things such as pain relief or anxiety, that may be required at any time of day or night. There were no measures in place to ensure people would be administered their medicines at night if required.

In addition to the above we found several other concerns with medicines. Medicines records were not always completed appropriately to ensure safe administration and directions for use were not always followed. These issues posed a further risk that people may not receive their medicines as prescribed.

There was a risk people may fall down the stairs. There were several people living with dementia who were mobile and who were observed to walk without known purpose, for most of their time. Access to some

staircases was restricted; however, the main staircases were only restricted from the top. This meant people could go up the stairs and consequently there was a risk they may fall down the stairs, particularly for those at risk of falls. Issues with staffing numbers and deployment meant there were not always staff in the area to monitor. This meant there was a risk people may access this staircase unobserved by staff and this placed them at risk of harm.

The home was not clean and infection control practices were not followed. The local Infection Prevention and Control team had conducted an audit at Bluebell Lodge in November 2018. This cited a deterioration in standards since the previous audit in February 2018. Issues were found in relation to the cleanliness of the environment, furniture, decorative fittings and equipment, waste disposal, cleaning practices and the availability and use of cleaning products and personal protective equipment (PPE). Throughout our inspection we found similar issues. Some areas of the home, such as bedrooms and corridors were odorous. Some pressure cushions had been penetrated with bodily fluid and some items of equipment, such as wheelchairs and some slings, were not clean. We observed that communal items, such as wheelchairs, slings and pressure cushions were not cleaned between uses. Staff did not always follow infection control practices. Several members of the management team had long false nails which could harbour bacteria and staff did not always use PPE for instance when entering the kitchen. These unhygienic practices increased the risk of infection spreading.

This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not protected from abuse and improper treatment. Safeguarding referrals had not been made when allegations had been raised against staff. A serious complaint had recently been made which contained several allegations against staff members. Despite this, no referral had been made to the local authority safeguarding adults team to enable independent investigation of these concerns and no internal investigations had been completed. Safeguarding referrals had also not been made in response to physical altercations between people. For example, records showed one person had hit another person causing them to fall to the floor. This had not been referred to the safeguarding adults team and there had been no internal investigation. At the time of our inspection, there were approximately eight safeguarding cases with the local authority safeguarding adults team, none of these had been referred by the home, all referrals had been made by external professionals or family members. The failure to make safeguarding referrals and act to reduce future risk placed people at risk of abuse.

Before our inspection we received concerns about the approach of some staff members. During our inspection we observed instances of punitive behaviour management from staff that did not respect people's rights or reflect current behaviour management good practice guidance. For example, one person was shouting and swearing at another person. The registered manager intervened and shouted at the person telling them they must leave the room and go and sit elsewhere. There was no attempt at de-escalation or distraction. This was a restrictive approach to behaviour management which did not respect people's rights.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection in March 2018 we found there were not enough staff to ensure people's safety. This was a breach of the legal regulations. At this inspection, we found continued concerns in this area.

People were at risk of harm as staff were not deployed effectively. Before and during our inspection, we were made aware of concerns about inadequate staffing levels. Throughout our inspection, we observed this to

be the case. For example, we observed that a person who was at risk of falls, was left unattended in the dining area for a period of twenty minutes. In addition, we had to intervene in a verbal altercation between two people as there were no staff present. A failure to deploy staff safely placed people at risk of harm.

There were not enough staff deployed at night to meet people's needs and ensure their safety. The registered manager told us, and staffing rotas confirmed, that two staff were deployed on night shifts. The complexity of people's needs and layout of the home meant that areas of the home were left unattended which meant there was no capacity to respond to emergency situations. Staff commented there were not enough staff and said nights were particularly hard. One member of staff raised concerns about what would happen if there was an accident at night time. The registered manager said she knew more staff were needed at night and was awaiting recruitment checks on a member of night staff. Despite this, there were no interim arrangements in place to ensure there were enough staff to keep people safe.

People were supported by staff who did not have the competency to ensure their wellbeing or safety. During our inspection additional agency staff were deployed at the home. During visits to the home on 15 and 16 December 2018 the local authority found that agency staff were not provided with any information about the people's care needs. We spoke with a member of agency staff who told us they had not seen any care plans. This placed people at risk of receiving unsafe support that did not meet their needs.

Furthermore, agency staff had not been briefed about risks. We observed a member of agency staff member was solely responsible for supervising the dining area. This member of staff had not been made aware that one person in the room was at high risk of falls, having sustained two falls in the previous 24 hours. This placed the person at risk of further falls.

This was an ongoing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

## Is the service effective?

### Our findings

People were not offered enough to eat. We observed people were served small portions of food and those who ate all their food were not offered more. One person did not eat their food as they did not like it. Staff cleared the plates away without noticing this, consequently no alternatives were offered. We intervened and asked the kitchen to prepare an alternative. The person ate all of this. This person would not have eaten an adequate amount if we had not intervened. We also observed instances where people asked for more food but this was not provided.

People were not always offered assistance or encouragement to eat. One person was asleep during lunch, staff did not offer them assistance to eat. Consequently, they only ate three spoonsful of pudding. Records showed another person was known to refuse meals and they had recently had lost weight. At lunch time staff asked the person if they wanted lunch, the person declined and walked off. Staff did not attempt any alternative techniques to encourage them to eat. Consequently, the person had no lunch. Furthermore, food records did not consistently evidence that people had been offered meals. This placed people at risk of poor dietary intake.

People were at risk of dehydration. Food and fluid records did not evidence people had been provided with enough to drink. Records showed some people were offered as little as 350mls of fluid a day. The average daily recommended intake is 1500ml. There was also no evidence that action was taken when fluid intake was very low. Fluid records for one person showed they consumed very little in a day. The following day the person was offered and consumed even less. This placed people at risk of dehydration.

People were at risk of unplanned weight loss which could have had an adverse impact on their health. People's weights were not effectively monitored which had led to a failure to identify fluctuations. Records indicated that one person had lost approximately 18 kg over a four week period. This had not been identified by the home and they had not taken any action to try to reduce this risk. Furthermore, food and fluid charts for this person did not demonstrate they were offered adequate amounts to eat and drink.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People's rights under the Mental Capacity Act (2005) (MCA) were not respected. Where people's capacity to consent to their care and treatment was in doubt, the necessary assessments had not been completed to ensure care was in their best interests and the least restrictive option. Medicines records showed one person was administered medicines covertly (in food or drink without their knowledge or consent.) Despite this,

there was no assessment of their capacity ensure this was the least restrictive option. Another person was subject to restrictions on their rights, freedom and privacy. This included restrictions on smoking which had led to behavioral incidents and restricted access to their bedrooms which led to agitation. There were no capacity assessments in these areas and no evidence that staff had considered the least restrictive options. In addition to the above, CCTV was used throughout communal areas of the home. There was no written record of consent and no evidence that the rights of people who could not consent had been considered under the MCA.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Conditions imposed on Deprivation of Liberty Safeguards (DoLS) authorisations were not met. Conditions are imposed on DoLS when authorised to ensure people's rights are respected in the least restrictive way. A DoLS had been granted for one person with conditions related to medicines, mental capacity assessments and care plans. Action had not been taken to comply with any of the conditions. This was also a concern with two other people's DoLS authorisations we reviewed. Furthermore, several people's DoLS authorisations had expired and had not been reapplied for. This meant these people were being deprived of their liberty without the necessary authorisations.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Care and support was not properly planned and coordinated when people moved between different services. People's needs were not assessed in a timely manner when they moved into the home. On the first day of our inspection we found three people who had recently been admitted to the home had no risk assessments in place. One person had a pressure ulcer and was at high risk of falls, there were no risks assessments in these areas. Consequently, measures in place were not sufficient to reduce risk.

People's health and wellbeing was placed at risk due to potentially unsafe discharges from hospital. One person was due to be discharged from hospital during our inspection. However, the provider had not sought information about the person's prognosis from the hospital so were unaware of any changes to their care or indeed whether their needs could be accommodated. Furthermore, we highlighted that the person's mattress cover was not fit for purpose. The cover had deteriorated which could have been an infection control or tissue viability risk and consequently it was no longer safe for use. This had not been identified by the provider. This failure to effectively plan admissions meant there was a risk people needs may not be met safely or effectively.

People's health needs were not met. People did not always have access to support from external health care professionals. Records showed that an important health appointment had been missed for one person, this could have had a negative impact on their health. Referrals were not always made to specialist health professionals. Another person had sustained eight falls in the previous six months. Despite this, no referral had been made to the local falls prevention team for advice.

People's needs were not reviewed when their health needs changed. During our inspection, one person was diagnosed with an infection. It was clear this had had a negative impact on their mobility and they had sustained two falls in 24 hours. Despite this, their mobility needs were not re-assessed and staff continued to

try to get the person to walk. Consequently, throughout the day, we observed the person had trouble mobilising and staff did not know what to do. As a result, they were left in the same position for five hours. This failure to review people's needs as their health changed had a negative impact on the support people received.

Staff did not always have a good understanding of people's health needs. We asked a staff member why one person was on a fluid restriction. They told us they were discharged from hospital with the restriction in place but they were unsure why. This posed a risk staff may not notice deteriorations in people's health. When people had specific health conditions, care plans did not consistently contain adequate detail for staff to provide effective support. For example, one person had a health condition but their care plan did not contain any information about it or how to manage the risks associated with it. This lack of information placed people at risk of not receiving the required support.

The treatment and care people received at the home was not always delivered in line with current legislation, standards and evidence based guidance. Although nationally recognised good practice risk assessments, such as pressure ulcer risk assessments, were used this was inconsistent and guidance was not always followed. For example, a member of staff told us the frequency of repositioning depended upon which member of staff admitted the person to the home, rather than good practice guidance. Staff lacked knowledge of good, safe practice in some areas. During our inspection we found drinks thickener unattended in a person's bedroom. This could have been accessed by people living at the home. Drinks thickener poses a serious risk to people if ingested and should be stored securely. The registered manager told us they were not aware of storage requirements. Failure to follow national guidance placed people at risk of harm.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported by staff who did not have the required skills or competency to provide safe and effective support. Although records showed staff had training in some areas including safeguarding adults, first aid and moving and handling this had not always been effective in ensuring staff competency. For example, although most staff had safeguarding training, appropriate action had not been taken to ensure people were protected from the risk of abuse and improper treatment. All but one member of staff had moving and handling training, however, during our inspection we observed widespread poor practice in this area. The failure to ensure staff competency in key areas meant people did not receive safe support that met their needs.

The environment did not fully accommodate people's needs. Bluebell Lodge was situated in a purpose-built premises. Consideration had been given to people's needs in the design and decoration of the building. For example, aids and equipment had been installed in some areas to enable people with mobility needs to navigate around the building. Some parts of the home were poorly maintained. For example, in the lounge the seats were observed to be in a dilapidated condition and not supportive of people's posture or comfort. There was limited evidence to demonstrate that people's needs associated with dementia had been considered in the design and decoration of the environment. Several people were living with dementia and we observed that some had difficulty navigating their way around the building. Some signage on doors was confusing and an inconsistent approach had been taken to helping people orientate themselves. The use of dementia friendly signage and colour schemes was also inconsistent throughout the home. This meant we were not assured the provider had taken all reasonable steps to accommodate people's diverse needs in the design and decoration of the building.



## Is the service caring?

### Our findings

People's right to privacy was not always respected. During our inspection we observed people's privacy was not respected as people frequently entered other people's bedrooms uninvited. There were not always staff available to prevent this from happening. Staff did not always respect people's privacy. For example, we saw the maintenance person mending furniture in a person's bedroom while they were asleep. Furthermore, staff talked openly about people's personal care and continence needs in communal areas.

Staff did not always recognise when people needed support. Throughout our inspection we had to intervene on several occasions to ensure people got the support they required. For example, one person fell asleep with their head on the table, we had to ask the staff member present to make the person more comfortable. When staff did identify that people needed support, they did not always have time to give it themselves, or to ensure that someone else did. One person had to ask several members of staff for assistance to go to the toilet before they were given the support they needed.

People's distress or discomfort was not always responded to promptly or consistently. We observed one person calling out in pain. Staff were present in the room but did not respond to this. Although staff were not being intentionally unkind they seemed to not notice when people were distressed. Another person was calling out from their bedroom as they were uncomfortable in bed and unable to reposition. There were no staff available to respond to meet this person's needs and ensure their comfort.

Although we received some positive comments about some staff members this was based on the caring approach of individuals rather than a culture of person centred care. We observed that many staff interactions were focused on tasks. Conversations between staff and people living at the home were limited and functional. For example, a member of staff assisted a person to eat but did not try to engage the person in any conversation. The registered manager did not encourage or support staff to provide care and support in a compassionate and person-centred way.

Staff routines took priority over person centred care and people's preferences. For example, one person was told they would have to wait for the tea trolley until they could have a hot drink. There were some institutional practices in place, for instance a 'bath rota' was in place specifying which day people would be offered a bath. There was no evidence that this was based upon people's preferences.

People told us they were supported to maintain their independence. However, we found care plans did not clearly reflect what support people needed or areas where they were independent. This posed a risk that people may get inconsistent support. We also received feedback from a specialist health professional who shared concerns that staff did not always identify when people's physical abilities had declined and consequently used unsafe techniques to support people to move. This meant people did not always receive support that met their needs.

We received mixed feedback about people's involvement in choices and decisions. Most people who could communicate their wishes told us they were offered choices and these were respected by staff. However, we



observed that when people were not able to make their wishes known easily staff did not always involve them in decisions. Staff did not use accessible means of communication or make sure that people understood them. For example, we saw staff deciding where a person was going to sit. They talked about the person rather than to them. Staff did not always communicate with people to explain the support they were providing. During our inspection, there were some instances where staff didn't explain to people what was happening during transfers with hoists. We observed occasions where staff approached people from behind and moved their wheelchairs without warning.

Some people and their families told us they had been involved in planning their support. However, others commented that they had not been involved and did not know if they had a care plan or not. This demonstrated there was an inconsistent approach to involving people in decisions about their care and support.

Despite the above, people and their relatives commented positively on the staff, considering them kind, caring, approachable and friendly. One person told us, "They're very friendly and helpful. I get everything I need." This view was also shared by people's relatives. One relative commented, "The staff are approachable and friendly."

People were supported to maintain relationships with friends and family, and people's friends and relatives were welcome to visit Bluebell Lodge. There were no restrictions upon visitors to the home.

## Is the service responsive?

### Our findings

People were not provided with adequate levels of basic personal care. On the first day of our inspection we observed that approximately 15 people had very poor levels of personal care. They had very dirty nails which appeared to be encrusted with bodily matter, greasy hair, flaky scalp and dry skin. There was no documentary evidence of people being offered baths or showers. Although a member of staff told us people did have showers our observations did not indicate this was the case. When we returned on 17 December 2018, despite raising our concerns to the provider, we observed that many people still had poor standards of personal care. The extent of this poor care was undignified.

People were at risk of receiving unsafe support that did not meet their needs. Care plans were contradictory and did not reflect people's needs. Three people had no care plans in place at all, just a summary sheet of their most basic needs. This meant there was no information about what mattered to these people or how best to support them. Other care plans were not regularly reviewed and so were out of date. Consequently, we found staff knowledge of care and support was variable and people did not always receive safe support that met their needs. We observed that one of the above people needed support with their mobility, there was no written information about how to do this and staff we spoke with told us they were not sure how to assist the person to move. We observed staff transfer another person into an arm chair. They placed their feet in inflatable heel protectors (used to prevent pressure damage) and used the heel protectors to prop up their legs. They did not place the person's feet on the foot rest. The person called out for a period of around 15 minutes – stating they were in pain. Another member of staff entered the room and provided a footrest, and the person stated that they were more comfortable and stopped calling out. A failure to provide support to meet the person's needs resulted in them experiencing avoidable pain and distress. Poor care plans and variable staff knowledge placed people at risk of unsafe, inconsistent care that did not meet their needs.

People's end of life needs and wishes were not planned for. The registered manager told us two people were nearing the end of their lives. There were no plans in place about their end of life wishes. Care records did not evidence they received support in key areas such as pressure relief, food and fluid and mouthcare and there was no information about when 'as required' pain medicines should be administered to ensure their comfort. This posed a risk that their end of life needs in relation to pain management, hydration, nutrition and care may not be met.

The care and support provided at Bluebell Lodge did not reflect people's preferences. There was a significant lack of meaningful activity. During our inspection we observed that, other than visits from friends and relatives, many people lacked meaningful occupation. Although an activity coordinator was employed, we observed their time was either taken up by providing one to one support or assisting staff with people's day to day care needs. Routines were dominated by meals and personal care and, the remainder of the time, people spent time in their bedrooms or communal areas listening to music, watching TV or sleeping. The lack of meaningful occupation and activity did not meet people's needs.

Several people spent long periods of time in their bedrooms alone and we saw no attempt to interact with them socially or provide the opportunity for occupation; this did not meet their social needs and may have

had a negative impact on their wellbeing. We observed that two people were left in their bedrooms, in bed all day, they did not have any music or television on in their bedrooms and when observed they were asleep or withdrawn. This lack of interaction and stimulation did not meet people's needs and put them at risk of isolation and resultant psychological distress.

There was a risk people's diverse needs may not be met. There was little evidence in care plans that people's needs associated with characteristics such as race, culture, religion or disability had been considered. The registered manager held traditional views of people from cultures different from her own and referred to groups of people with traditional, derogatory terms.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were not always recorded or responded to in line with the provider's policy and appropriate action was not always taken in response to complaints. A complaint had been received about the conduct of a staff member. The record stated this had been addressed with the staff members involved. However, there was no record of this in the complaints file or in the individual staff file. A complaint from a person's relative had been recorded in the complaints file, but there was no information about what the complaint was or what had been done to resolve the complaint. A third complaint had raised serious concerns about the conduct of a staff member, despite this no action had been taken to investigate and reduce any immediate risks to people. This failure to ensure people's complaints were acted upon meant opportunities to improve the quality of service provided had been missed.

# Is the service well-led?

## Our findings

It is of significant concern that several serious breaches of regulation at Bluebell Lodge had not been addressed prior to our inspection. This is of particular concern given the history of non-compliance with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a failure to act on the concerns resulting from our last inspection. During our March 2018 inspection, concerns were identified about multiple aspects of the service. We received an action plan which provided assurances that all required improvements would be completed by 30 June 2018. Despite this, during this inspection we found ongoing concerns across a range of areas. For example, the March 2018 action plan stated staff would be deployed in line with levels determined by the provider. However, during our inspection we found significant concerns about staffing levels which placed people at risk of harm. The action plan stated the manager would 'perform regular walkabouts to informally observe and take prompt corrective action if required.' However, the registered manager told us they had not completed daily walkabouts for some time and we saw there were no records of this since August 2018. Consequently, cultural and practice issues in the staff team had not been identified and addressed and this had resulted in people's needs not being met. This failure to take effective action to address the concerns identified in our previous inspection resulted in continued concerns about the quality and safety of care and support provided at Bluebell Lodge. This placed people at risk of harm.

Systems to monitor and improve the quality of the service were not robust. Although there were processes in place to monitor the quality and safety of the service these were not effective. Consequently, these systems had not identified all issues identified during our December 2018 inspection. For example, medicines audits were not effective in identifying issues. Consequently, we found multiple concerns about the management and administration of medicines.

Where audits had identified areas for improvement swift action had not been taken to address issues. A medicines audit conducted by an external pharmacist in September 2018 had identified a wide range of concerns. At our inspection, we found many of the same issues in relation to medicines management. This failure to make improvements placed people at prolonged risk of not receiving their medicines as prescribed.

Systems to record, analyse and learn from significant incidents were not effective. The registered manager told us they completed quarterly falls analysis. However, these were basic and did not identify patterns and trends of falls, such as repeated falls sustained by the same person, time of day and location of falls. These audits were not timely which meant opportunities to reduce risk may have been missed. For example, records showed one person had fallen three times in October and November 2018. But because the quarterly falls analysis had not been completed for this period opportunities to take timely action to reduce risk had been missed.

Incidents such as verbal and physical altercations were recorded on behaviour charts, but, there was no system to escalate concerns to the management team and no processes for the collation and analysis of

these incidents to reduce the risk of future occurrences. The failure to review and take appropriate action in response to these incidents placed people at risk of harm.

Effective action was not taken to address concerns raised during our inspection. Following our inspection visits on 11 and 12 December 2018 we received an initial action plan from the provider. This did not provide adequate assurances about how the urgent risks identified during our inspection would be addressed. For example, in relation to concerns about poor moving and handling the provider advised training was to be arranged. However, there was no assurance about what immediate action would be taken to reduce risk to people or how staff competency would be assured. The action plan stated the registered manager would ensure staff followed the correct risk assessment procedures, however, this did not address the immediate concerns identified about the registered managers poor knowledge of risk assessment and management. This meant we remained concerned that people were placed at risk of harm.

As we were not assured by the initial action plan, we wrote to the provider detailing our concerns and asked them to take urgent action to address the serious concerns outlined in this report. Following review of the second action plan we remained concerned that people were exposed to the risk of harm. Several of the timescales detailed in the letter did not reflect the seriousness of the risks. For instance, restriction of access to the stairs was not planned to be completed until mid-January 2019. There were concerns that were not clearly addressed by the action plan. For example, the action plan did not clarify what immediate measures would be taken to ensure there were medicines trained staff on night shifts. In addition, we were concerned that some aspects of the action plan may not be achievable in the given timescale. Many actions were allocated to the provider and 'interim manager'. However, the interim manager had not been recruited which meant all the actions were scheduled to be completed by provider.

We had concerns about the competency of the leadership team. It was of serious concern that the provider told us on 12 December 2018, that they were "not surprised" about the initial findings of the inspection, and stated they were already aware of, or had witnessed, issues such as poor moving and handling practices. They told us they had a contingency plan that they would deploy due to the feedback provided by us on 11 December 2018. However, it was unclear, why this contingency plan had not been deployed sooner. This failure to address areas of serious concern meant people had been receiving unsafe support, that did not meet their needs for a prolonged period. Throughout our inspection visit on 17 December 2018 we found the directors lacked operational knowledge about the home. The approach to addressing the issues identified in our inspection was not well organised or managed. On 17 December 2018 we found the implementation of improvement plans was disorganized and there was a lack of effective oversight of planned action. For example, moving and handling training had been booked for the 17 December 2018; however, no staff had been released to attend the training so the morning session was cancelled. A team leader had been working on implementing care plans for people who did not have one. Some parts of this were on the electronic system, some were paper based and the team leader struggled to locate newly developed care plans. These had not been shared with care staff. This meant we had limited confidence in the provider and management team to make the required changes to ensure people's safety and wellbeing.

There were limited opportunities for people to influence the running of the home. This was reflected in people's comments, most people told us they were not asked for their views on the service and did not recall attending any meetings. Although people and their families had the opportunity to complete satisfaction surveys, there had not been any recent meetings for people living at the home. This meant opportunities to improve the service may have been missed.

Although, there was evidence to demonstrate the provider had been in contact with other agencies, feedback from health and social care professionals was poor. Several professionals shared concerns with us

about the conduct of the care team, staffing levels and management. We found evidence to support concerns raised by professionals throughout our inspection and this is presented in this report.

There were limited opportunities for staff to get involved in the running of the home. Although there were regular meetings for staff, these mainly focused on trying to address performance issues. Feedback from staff was mixed. Some staff told us they enjoyed working at the home and felt well supported. Other staff felt the service was not well led. One member of staff told us the quality of the service had deteriorated, they commented, "It is much worse now."

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had not ensured that we were notified of incidents at the service, which they are required to by law. There had been a failure to notify us of safeguarding incidents which had occurred at the home. A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating in the home. The provider did not have a website.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents  There had been a failure to notify CQC of safeguarding incidents which had occurred at the home.  Regulation 18 (1)

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 did not receive basic care. People were not involved in decision making and care did not meet people's needs or reflect their preferences.  Regulation 9 (1)

### The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  People's rights under the Mental Capacity Act 2005 were not protected.  Regulation 11 (1)

### The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  People were placed at risk of harm as risks were not safety managed.  People did not receive their medicines as prescribed.  Environmental risks were not managed safely.  People were not protected from the risk of infection.  Regulation 12 (1)

### The enforcement action we took:



We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment  People were not protected from abuse and improper treatment.  Regulation 13 (1)

**The enforcement action we took:**

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs  People were at risk of malnutrition and dehydration as they did not have enough to eat and drink.  Regulation 14 (1)

**The enforcement action we took:**

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems and processes to ensure the safety and quality of the home were not effective. This placed people at serious risk of harm.  Regulation 17 (1) (2)

**The enforcement action we took:**

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  There were not enough staff to meet people's needs and ensure their safety.  People were supported by staff who did not have the required skills or competency to provide safe and effective support.  Regulation 18 (1)

**The enforcement action we took:**

We took action to cancel the registration of the provider.