Bluewater Care Homes Limited

# Bluewater Nursing Home

## Inspection report

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Portsmouth
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## Ratings

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| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Bluewater Nursing Home is a residential care home providing personal care to 24 people aged 65 and over at the time of the inspection. Some people were living with dementia. The service can support up to 60 people. Although it is called a 'nursing home', it does not provide nursing care.

The home is based on three floors with an interconnecting passenger lift, although only the lower two floors were in use at the time of the inspection. The home is in the heart of Portsmouth, close to local amenities.

People's experience of using this service and what we found
People and their relatives were positive about all aspects of the service and the care provided.
However, we found a new medicines system needed further time to embed, to ensure accurate records of medicine administration were maintained.
Risks were usually managed safely. However, the system to ensure pressure-relieving mattresses remained at the right setting was not always effective and risks relating to the management of a person's diabetes were not fully recorded.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, records of mental capacity assessments were not always robust.
Quality assurance systems were in place, but had not always been effective.
Infection control risks were managed appropriately.
Safe recruitment procedures were followed and there were enough staff to meet people's needs.
People were treated in a kind, caring and compassionate way by staff who were competent and understood their needs.
People were supported to express their views and be involved in decisions about their care and the running of the service.
Staff were clear about their safeguarding responsibilities and knew how to recognise and report potential abuse.
Staff carried out their roles and responsibilities effectively. They had a good understanding of managing risks.
People's nutritional needs were met, and they were supported to access health and social care professionals if needed.
People's care and support needs were met in a personalised way.
Adaptations had been made to the home to meet the needs of people living there and imaginative use had been made of the communal areas.
People were supported to access a range of activities, including trips to the local community.
People's end of life wishes were explored and recorded in their care plans.
People knew how to raise concerns and there was an accessible complaints policy in place.
People and their relatives had confidence in the management and said they would recommend the home.
Managers worked in an open and transparent way and understood their regulatory responsibilities.
Positive links had been developed with community groups that benefited people.

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 requires improvement (report published in February 2019) and there were two breaches of regulation. Following the inspection, we imposed conditions on the provider's registration, including sending the results of monthly audits to CQC, together with any resulting action. All imposed conditions were fully met. At this inspection we found some improvement had been made, but the provider was still in breach of Regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified a breach of regulation in relation to governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

We always ask the following five questions of services.

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| **Is the service safe?**<br>The service was not always safe.<br>Details are in our safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was effective.<br>Details are in our effective findings below. | **Good** |
| **Is the service caring?**<br>The service was caring.<br>Details are in our Caring findings below. | **Good** |
| **Is the service responsive?**<br>The service was responsive.<br>Details are in our Responsive findings below. | **Good** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our Well-led findings below. | **Requires Improvement** |

# Bluewater Nursing 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 Care Act 2014.

Inspection team
The inspection was conducted by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Bluewater Nursing Home is a 'care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about important events the service is legally required to send us. We also considered information the provider sent us in the provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection, we spoke with seven people living at the home and nine family members. We spoke with 12 members of staff including an administrator, a cleaner, five care workers, the head of care, the registered manager, the provider's quality performance manager, a director of the provider's company and

the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a visiting healthcare professional.

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 due to cognitive impairment.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
After the inspection, we continued to seek clarification from the provider to validate evidence found. We also sought feedback from a healthcare professional and four social care professionals who regularly worked with the service.

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 the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. 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 our last inspection the provider had failed to ensure all risks relating to the safety and welfare of people using the service were assessed and managed effectively. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014. At this inspection, we found action had been taken and there was no longer a breach of this regulation. However, further improvement was still required.

• People were usually protected from the risk of harm. Relevant risks had been assessed and recorded, along with action staff needed to take to mitigate the risk. For example, risk assessments were in place for people at risk of developing pressure injuries.
• Where pressure-relieving equipment was needed, this had been provided. However, for one person we found their pressure-relieving mattress was not at the optimum setting to be effective. This put the person at increased risk of developing pressure injuries, although their skin was intact at the time of the inspection. We raised this with the registered manager, who adjusted it and put additional measures in place to help ensure all pressure-relieving mattresses remained at the correct setting in future.
• For another person, their diabetes care plan advised staff what to do if their blood sugar levels were too low, but there was no information recorded to advise staff what to do if they were too high. However, the risks associated with this were mitigated as staff were aware that this person was prone to high blood sugar levels and were working with other professionals to manage this. We raised the recording issue with the registered manager who undertook to review and update the person's care plan.
• The risk of people falling was managed effectively. Risk assessments had been completed and people were supported to use walking aids safely. Following a fall, the person's falls risk assessment was reviewed and extra measures considered to reduce the risk of further falls. For example, the furniture in one person's bedroom was moved around to successfully make the environment safer.
• Other risk assessments in place included areas such as medicines management, behaviours, nutrition and the use of bed rails. Staff understood how to mitigate these risks.
• Checks of the water quality and temperatures were conducted regularly and records confirmed they were within acceptable safety limits. Lifting equipment, such as hoists, were maintained according to a strict schedule. In addition, gas and electrical appliances were checked and serviced regularly.
• Fire safety risks had been assessed and fire detection systems were checked weekly. Staff knew what to do if the fire alarm sounded. Personal emergency evacuation plans had been completed for each person, detailing action needed to support people to evacuate the building in an emergency.

Using medicines safely
• Arrangements were in place for obtaining, storing, administering, recording and disposing of medicines.

Staff had been trained to administer medicines and had been assessed as competent to do so safely.
• The home had recently introduced a new, electronic system for managing and recording the administration of medicines. Staff had been trained to use this but the system needed more time to become fully embedded in practice.
• For example, we identified 10 anomalies in the medicines recording system, which indicated people had received too many or too few tablets since the new system had gone live, three days before the inspection. Following the inspection, the registered manager investigated these anomalies, which they attributed to 'teething problems' with the recording processes on the new system. They told us they would provide additional support and training to staff who administered medicines and increase the frequency of medicines auditing.
• There were systems in place to help ensure the application of topical creams was completed safely. However, we found there were gaps in some of the cream recording charts, so we could not be assured that people had received these as prescribed. We raised this with the registered manager who told us they would monitor the completion of these charts more closely in future.
• The date creams had been opened was recorded, to help ensure they were not used beyond their 'use by' date. A professional from the Clinical Commissioning Group (CCG) medicines optimisation team told us there had been "big improvements" in the way staff managed medicines. A family member confirmed this and said, "I have no concerns about medicines, they [staff] are mindful of [my relative's] needs."
• For people who were prescribed medicines to be administered on an 'as required' (PRN) basis, there was clear guidance to help staff understand when to give them and in what dose. A family member told us, "They [staff] increase [my relative's PRN] medicines when she gets anxious."

Staffing and recruitment
• There were clear recruitment procedures in place. These included pre-employment reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions.
• All the people and relatives we spoke with told us they felt there were enough staff to meet their needs. One person said, "If you buzz, someone will come." Throughout the inspection, we observed that call bells were responded to quickly.
• Staffing levels were determined by the number of people using the service and the level of care they required. A comprehensive tool was used to help calculate staffing levels to ensure they remained at a safe level. A staff member told us, "[The registered manager] is very responsive at implementing additional staff if they are needed."
• People were supported by consistent staff. Short term staff absences were covered by existing staff members or a member of the management team; this helped ensure people received continuity of care.

Preventing and controlling infection
• The home was clean, hygienic and well maintained. Regular cleaning was completed, in accordance with set schedules.
• A family member told us, "It's always clean. If it wasn't I'd raise it with them. For example, there was a problem with hot water, in respect of legionella; I raised it with [the provider] and they dealt with it."
• People told us staff had arranged for them to be given the flu vaccine.
• Personal protective equipment (PPE), including disposable gloves and aprons were available throughout the home. In addition, people who used hoists had individual slings allocated to reduce the risk of cross infection.
• The laundry room was tidy and organised. Staff operated an effective system to reduce the risk of cross-contamination between dirty linen awaiting washing and clean linen that had been washed.

Systems and processes to safeguard people from the risk of abuse

• Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse. One staff member told us, "If I saw anything of concern, I would go straight to [the registered manager]. I can also report things to CQC if I need to."
• When asked if they felt safe living at Bluewater, one person told us, "I have no problems here."
• We viewed examples of investigations conducted by managers following allegations of abuse. These had been conducted thoroughly and in liaison with the local safeguarding team.

Learning lessons when things go wrong
• The registered manager described how they constantly monitored incidents, accidents and events to identify any learning which may help keep people safe.
• This enabled any trends or themes to be identified, so action could be taken to mitigate the risk and prevent reoccurrence. For example, following a series of medicine errors, they sought support from the CCG medicines optimisation team to implement a more robust medicines management system.
• Staff told us they felt they would be supported if they reported mistakes they had made. A senior staff member said, "Everyone makes mistakes. I stress to [junior staff]: Admit it, tell someone, inform the family, reflect and learn from it."
• The registered manager knew how to seek support from external professionals when they required additional guidance.

Good

# 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 the last inspection this key question was rated as Requires improvement. At this inspection this key question has improved to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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 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.
• Where people did not have capacity to make decisions, staff had completed MCA assessments, in consultation with those close to the person. Family members confirmed this, including one who told us, "[Staff] discuss everything with me."
• However, we found the assessments were not always robust as they covered a wide range of decisions. In addition, for one person, the assessment had not been followed by a best interests decision. This meant the provider could not demonstrate that decisions staff had made on behalf of the person were necessary or were the least restrictive option.
• We discussed this with the registered manager, who told us they were undertaking reviews of MCA records in people's care plans to ensure assessments and best interests decisions were properly recorded.
• Where people had capacity to make decisions, we saw they had signed their care plans to indicate their agreement with the proposed care and support.
• People's right to decline care was respected. Staff were clear about the need to seek verbal consent from people before providing care or support. A staff member told us, "If people decline care, we have to stop. We encourage them as much as we can, but sometimes have to leave and try again later."

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 and found they were. One person told us, "I get a lot of freedom here. I can come and go as I please; for example, yesterday I went out for a picnic with friends."
• DoLS authorisations had been made when needed. Where conditions had been attached to authorisations, these had been followed.

Supporting people to eat and drink enough to maintain a balanced diet
• People received enough to eat and drink and told us they enjoyed their meals. One person said, "The food is alright, and I'm a fussy eater. There's always a choice and I can have salad anytime I want, which I love."

Another person told us, "We are usually given the choice of two things and an alternative. The cook is very good."
• Each person had a nutritional assessment to identify their dietary needs. This included their likes and dislikes, together with information about how and where they preferred to eat. Where people required a special diet, for example a soft or low-sugar diet, this was provided. One person told us, "I'm lactose intolerant, and they get special milk in for me."
• People who needed help to eat and drink were supported in a safe and dignified way. For example, they were sat upright and patiently supported on a one-to-one basis.
• Staff monitored people's weight and acted if people started to lose weight; for example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories.
• One person told us, "They [staff] weigh me every fortnight, to make sure I don't lose any more weight." The family member of another person who was at high risk of losing weight told us, "[My relative] is on fortified drinks now. If she's hungry, [staff] will give her two breakfasts and extra lunch. [As a result], her weight is holding steady now."
• People were frequently offered hot and cold drinks and snacks, such as biscuits or fruit.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Comprehensive assessments were completed before people moved to the home. Care plans were then developed to include people's identified needs and the choices they had made about the care and support they wished to receive.
• Staff followed best practice guidance, which led to good outcomes for people. For example, they used a recognised tools to assess the risks of skin breakdown, choking and malnutrition.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. Their diverse needs were detailed in their care plans which included their needs in relation to culture, religion and diet, including gender preferences for staff support.
• We noted that some people had not been given an opportunity to discuss their sexuality. However, the registered manager showed us a new assessment form they were implementing that would include this.
• Staff had completed training in equality and diversity and told us they were committed to ensuring people's equality and diversity needs were met. There were policies in place to support this.
• Staff made appropriate use of technology to support people. An electronic call bell system enabled people to call for assistance when needed and movement-activated alarms, linked to the call bell system, were used to alert staff when people moved to unsafe positions.
• In addition, the provider had invested in an electronic care planning system. This was available to staff via hand-held devices, on which they recorded the care they provided at the time they delivered it. This helped ensure people's care records were up to date.

Staff support: induction, training, skills and experience
• People and family members told us staff were knowledgeable and competent. Comments included: "The care is superb" and "They're certainly doing a very good job".
• Since the last inspection, the provider had enhanced the training opportunities for staff. These now included face-to-face training, workbook-based training and computer-based training.
• New staff completed a programme of induction before being allowed to work on their own. This included a period of shadowing more experienced members of staff, followed by a competency assessment to check they were able to support people effectively.
• Staff who were new to care were supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.
• Staff refreshed and updated their training regularly to help ensure their knowledge remained up to date. They were also supported to gain vocational qualifications relevant to their role.

• Staff told us they felt supported in their roles. Comments included: "I get a lot of praise, and always get a thank-you at the end of the shift" and "I feel supported; we can always talk to [one of the managers] if we need to".
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Yearly appraisals were also completed, to assess the performance of staff and identify any development needs.
• The provider had also introduced 'champions' for aspects of people's care. These included: dementia and end of life care. The role of the champions was to keep up to date with best practice guidance and to share their knowledge with colleagues.

Adapting service, design, decoration to meet people's needs
• Adaptations had been made to the home to meet the needs of people living there; for example, a passenger lift connected the three floors of the home. Handrails in a contrasting colour to the walls were provided in corridors. Doors were extra wide to accommodate wheelchairs and hoists. Bathroom doors were painted in bright colours and were clearly signed to make them easier for people to find them.
• In some communal areas, however, we found there was a lack of suitable seating for people. As a result, people chose to remain in their wheelchairs which would not have been comfortable after a lengthy period. We discussed this with the registered manager who arranged for more appropriate chairs to be brought from an unoccupied part of the building and for chair raisers to be put under the legs of some of the lower chairs to make them easier for people to use.
• An imaginative range of age appropriate props had been used to decorate the home; these included old tools, posters and photographs.
• When asked what they liked about the home, a family member told us, "The freedom, size, open spaces. Here, residents are busy, there are many rooms to go into which keeps residents busy." Written feedback from another family member described the home as "joyously eccentric in its décor".
• Bedrooms had personal images or memorabilia attached to the doors to help people find their own rooms. There was a range of communal areas available to people, which gave people the choice and freedom to choose where they wished to spend their time
• Novel and imaginative use had been made of the large communal areas. For example, one area had been converted into an old-style cinema with original seats and a large screen. Another area had a replica 1930s railway carriage with authentic features and a screen to simulate travelling through a variety of different landscapes.
• There was a rolling maintenance programme in place to help ensure the building remained fit for purpose.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People and their relatives told us their health needs were met and if they ever felt unwell, a GP would be called without delay.
• People were supported to access other healthcare services including specialists, when needed, and to participate in regular health checks. For example, people were supported to access occupational therapists, the memory service, dentists, chiropodists and opticians.
• A visiting healthcare professional told us, "It's a really lovely home. It's never too busy. It's a happy place."
• Changes to people's health needs and any visits from healthcare professionals were documented in their care plans, together with any follow-up action required. This helped ensure a consistent and joined-up approach to meeting people's healthcare needs.
• If a person was admitted to hospital, staff followed the 'red bag' scheme. This is an initiative to help ensure key information about the person is sent to the hospital with them, so their needs could be understood by the medical team.

Good

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People spoke positively about staff, describing them as "kind" and "caring". Other comments included: "Staff are nice and kind", "I'm always happy to come back here when I've been out" and "[Staff] are lovely, because of the way they treat me: very politely, very helpful".
• Comments from family members included: "[Staff] are caring on every level", "They are always attentive and friendly", and "All the staff are kind and caring, very respectful".
• We observed positive interactions between people and staff. Staff were friendly, engaged in appropriate banter with people and approached them with respect. Whenever they spoke about people, they did so in a respectful, caring and affectionate way.
• Staff supported people in a calm, unhurried way. They also used touch, appropriately, to reassure people when they became anxious. When a person became upset, a staff member spoke softly, pulled a blanket around them and helped make the person comfortable in their chair.
• During discussions with staff, they demonstrated a good understanding of people's individual needs, preferences, backgrounds and interests. They used this knowledge to engage with people in a meaningful way.
• Staff had developed positive and caring relationships with the people they supported. They had a good rapport and interacted with people well, displaying warmth and kindness. One person told us they were particularly close to one staff member, but added, "All the staff are fine with me; they are like family." A family member said, "[Staff] are very friendly, I get on well with them."
• The provider had appointed two staff members, who had "infectiously happy" dispositions, as 'laughter champions'. We spoke with one of them, who told us their role was to "have a laugh with [people] and make them happy". We observed them doing this successfully in one of the lounges and people were smiling and laughing with them. A visiting healthcare professional told us, "They [staff] really make an effort to make sure people are happy."
• Staff recognised people's diverse needs and respected their individual lifestyle choices. There were policies in place that supported this practice.
• The home had recently organised LGBT (Lesbian, gay, bi-sexual and transgender) pride events to celebrate diversity. Photos from the events showed around 50 people, including family members and staff attended, together with people from the local community. A family member told us the events were well-received by people, who they said enjoyed the events "very much".
• People were supported to follow their faith. One person told us, "I go out every Sunday to church and they [staff] always make sure I'm ready." A service was held within the home every month, with a minister from a local church. There was also a small prayer area for people to use.

Supporting people to express their views and be involved in making decisions about their care
• People were involved in discussing and planning the support they received. Written feedback from a family member said, "It felt like a caring partnership between you [staff], [my relative] and the rest of the family."
• Records showed that people, and their relatives where appropriate, had regular meetings with senior staff to discuss their care plans and make changes to their support arrangements. A family member confirmed this and said, "I'm always offered to see [my relative's] care plan and they [staff] discuss it with me when they review it."
• Staff ensured that family members and others who were important to the person were kept updated with any changes to the person's care or health needs.
• We heard people being consulted throughout the inspection about where they wished to go and what they wished to do.

Respecting and promoting people's privacy, dignity and independence
• We observed staff treating people with dignity and respect throughout the inspection, using their preferred names.
• Staff described how they protected people's privacy during personal care. This included listening to people, respecting their choices and closing doors and curtains. We saw people were asked discreetly if they needed help with anything, including using the bathroom.
• People told us staff always knocked before entering their rooms. One person said, "Yes, they knock even though the door is open during the day." We also observed staff knocking on bathroom doors before entering.
• Care records were kept securely. Information on the computer was password protected and restricted to those who needed to view it.
• Staff promoted people's independence. For example, one staff member told us, "It's all about independence; if people can wash themselves, we encourage it."
• Care plans also encouraged staff to promote independence; for example, describing things people could do for themselves if given encouragement to do so.

Good

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant People's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People told us their needs were met in a personalised way and this was confirmed by family members. Comments included: "I like to get up late and they [staff] are happy for me to have a lay-in" and "They attend to [my relative's] needs flexibly and are responsive to ideas". Written feedback from a family member described the care and support as "high on individualism".

• Care plans had been developed for each person and provided sufficient information to enable staff to support people in a personalised way. These were updated monthly or when the person's needs changed.

• However, some care plans lacked key information about people's health conditions. For example, for a person living with chronic obstructive pulmonary disease (COPD), a support plan was not in place, although some generic information was included as an embedded document in the person's file. Another person's care plan contained inaccurate information about pain control; and a further person's care plan contained out of date information about the management of their diabetes.

• The risks were mitigated, however, as staff understood people's needs, wishes and preferences well and could explain them to us.

• We discussed this with the registered manager, who told us they were already working to improve the content of care plans and the consistency of recording. This included implementing a 37-point audit tool to help ensure care plans were up to date and reflected people's needs.

• Staff responded promptly to changes in people's needs. For example, following changes in one person's presentation, they had sought advice from the community mental health team, who increased the person's medicines. When staff noticed this made the person too sleepy to eat, they worked with the mental health team to adjust the timings of the medicine to overcome the problem.

• People were empowered to make their own decisions and choices. People confirmed they could make choices in relation to their day to day lives; for example, what time they liked to get up or go to bed, what they ate and where they spent their time. One person said, "I do what I want."

• A staff member told us, "Every day is different for [people]. For example, some days, [named person] can walk really well, but other days not and they use the wheelchair. They all have a choice based on how they're feeling."

• When ask how they supported people living with dementia to make choices, a staff member told us, "You have to go along with what they are saying, use signs and point to things; give simple choices with 'yes' or 'no' answers; Hold up clothes, for example, and limit the number of choices as it can be confusing."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People's communication needs were identified, recorded and highlighted in their care plans. This helped ensure that staff were aware of the best way to communicate with people, including those who struggled to communicate verbally.
• Information could be given to people in a variety of formats, including easy read, large print and pictorial. For example, some off the quality assurance questionnaires were available in a simple, accessible format to make them easier for people to complete.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People had access to a range of activities that encouraged social inclusion. These included armchair exercises, baking, bingo, music, quizzes and visiting animals. A family member told us, "They [staff] get [my relative] involved in things. She joins in and finds it stimulating."
• Activities had been tailored to meet people's individual interests. For example, a gardening club had been formed and we were told people had been taken on trips to choose plants for their rooms and for the kitchen garden.
• For people who were unable, or chose not to join in with group activities, staff spent time with them on a one-to-one basis. For example, a family member told us they had seen staff reading to their relative in their room and added, "One day, two [staff members] were in there singing and clapping along with her. She loved it."
• Since the last inspection, a minibus had been purchased to take people on trips to local attractions. For example, one person had visited a shop where they used to work and had spent time interacting with ex-colleagues. This had led to a commitment to making regular visits in future.
• People were encouraged to identify 'wishes' of things they would like to do and staff then supported them to achieve this. For example, one person expressed a wish to paddle in the sea, so they were taken to the coast where they were able to do it. Another person wanted to go 'scrumping'; the provider obtained permission from a landowner and the person was supported to collect apples which were then used in the kitchen.
• A 'pub' had recently been built in part of the dining room. This was due to open the weekend after our inspection and would provide a further opportunity for people to meet and socialise.
• Special occasions, such as people's birthdays and anniversaries were celebrated and people were encouraged to invite family members to join them. One person described the atmosphere at Bluewater House as "like one big family".

End of life care and support
• At the time of the inspection, no one at the home was receiving end of life care. However, staff had experience of supporting people at the end of their lives and demonstrated a commitment to supporting people to have a dignified, comfortable, pain free death.
• A family member told us staff had nursed their relative "back from the brink" twice. They said, "She wasn't expected to live. [A senior staff member] didn't leave her bedside, she stayed up all night with her, making her comfortable, giving her fluids, and brought her round." Written feedback from the family member of a person who had recently died at the home said, "End of life care was provided [to my relative] with skill and kindness to all."
• Some staff had also completed the 'six steps' end of life training programme with a local hospice, with a view to cascading their knowledge to other staff. This is a programme designed to support staff in care homes to deliver high quality, compassionate, end of life care.
• People's end of life wishes were usually recorded in their care plans. Although some were still being developed, others were very detailed. The registered manager showed us a new form they had developed,

following the six steps training, to enhance the information gathered about people's end of life needs and preferences.
• One person had an advanced care plan that gave clear guidance to staff about the action to take if they experienced a choking episode and staff understood what was expected of them.
• Links had been developed with community nurses and palliative care services to enable staff to seek specialist advice and support if needed.

Improving care quality in response to complaints or concerns
• There was an accessible complaints procedure in place and people told us they would feel happy raising concerns. A family member told us, "Things are taken notice of; for example, we said the coffee area was looking tired and it's being addressed."
• Records of complaints showed they had been investigated and dealt with thoroughly, promptly and in accordance with the provider's policy.
• The registered manager described how they used learning from complaints to help drive improvement and gave examples of when they had done so. For example, in response to concerns raised, they were employing a second housekeeper to provide better cover in the laundry to help ensure people's clothes did not get lost or damaged.

Requires Improvement

# 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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant recording and quality assurance systems were inconsistent and did not always support the delivery of safe, high quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to operate effective systems to assess, monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014. At this inspection, we found some action had been taken, but there was a continuing breach of this regulation.

• The provider's quality assurance system comprised a wide range of audits, but these had not always been effective in ensuring people's records were properly maintained. For example, we identified: that records relating to medicines and topical creams were not always accurate; that the system to ensure pressure mattresses remain at the right setting was not always effective; that risks relating to the management of diabetes were not always fully recorded; that mental capacity assessments were not always robust; and that some care plans lacked key information.

The failure to maintain accurate, complete and contemporaneous records in relation to each person using the service, including a record of the care and treatment provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014

• Since the last inspection, the provider had recruited a quality performance manager to oversee quality assurance at the home. They were in the process of enhancing and developing the current systems to make them more robust. This would help ensure they were more effective in the future.
• They had also introduced competency assessments of staff practice to monitor the quality of care provided and to identify any training needs. Staff told us the assessments were done in a supportive and helpful way.
• Where improvement actions had been identified, we saw they were monitored using rolling action plans with completion dates and details of the staff responsible for completing them.
• There was a clear management structure in place, which had recently been enhanced to provide more resilience. It consisted of a director of the provider's company, the nominated individual, the registered manager, the quality performance manager and the head of care. Each had clear roles and responsibilities.
• Staff understood their roles and communicated well between themselves, for example during handover meetings at the start of each shift, to help ensure people's needs were known. They also kept an appointments board so they knew when people needed to attend medical and other appointments.

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

outcomes for people
• People and their relatives spoke positively about the management of the service and told us they would recommend the home to others. Comments included: "I would give [the home] a five-star rating" and "I've never experienced any negativity, it's running like clockwork".
• The provider had clear expectations about the values staff should work to and these were set out during their induction. These included person-centred care, promoting independence and supporting people to achieve their goals. These values were communicated to staff at recruitment, during one-to-one conversation with managers and during staff meetings.
• From our discussions with staff, it was clear they understood these values and were committed to meeting them during their day to day work.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider consulted people in a range of ways. These included quality assurance surveys, 'residents' meetings', one-to-one discussions with people and their families, and through an external website where people could post reviews.
• One person told us, "[The registered manager] is lovely, easy to talk to and would sort anything out." A family member said, "We are invited in every three months; we give feedback and constructive criticism."
• The registered manager acted on people's feedback. For example, in response to people's suggestions, they had introduced new activities, advertised the activities more clearly in people's rooms, and changed the system of staff delegation to help ensure people's beds were made earlier in the day. A family member told us "[Managers] are on the ball with everything. Any issues are always addressed."
• People were involved in the way the service was run, including in the recruitment process for new staff. The registered manager told us this was useful and said people's views were "important" and taken "very seriously".
• Staff told us they felt engaged in the way the service was run and that morale was good. They said they enjoyed a good working relationship with their colleagues and felt they worked well as a team.
• The provider's policies and procedures helped ensure the equality and diversity needs of staff were considered; for example, staff working hours had been adjusted to take account of their individual commitments and lifestyle choices.
• Staff spoke positively about the registered manager, describing them as "approachable" and "supportive". A new staff member told us, "Everyone is lovely. I've been made to feel welcome, part of the family." Comments from other staff included: "We are one big family and that includes the residents", "Management are more understanding now; they listen and are quick to respond" and "They [managers] are all approachable and I'm confident any concerns would be addressed".
• The provider expressed their appreciation of staff through the use of award schemes for 'employee of the month' and 'employee of the year'. A staff member who had received one of the awards told us it made them feel "really chuffed". Staff were also nominated for, and had received, external awards; for example, a staff member had received an award for end of life care from the Lord Mayor of Portsmouth.
• The provider also offered financial incentives for staff to complete all the required training. This demonstrated the importance they attached to staff learning and development.

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
• The registered manager was aware of their responsibilities under the duty of candour regulation. This is a requirement for providers to be open and transparent if things go wrong. The registered manager provided examples of when this had been followed, both verbally and in writing, as required. Written feedback from a family member said, "Any minor concerns I had were met with openness and responded to."
• The provider had prominently displayed the home's previous inspection rating in the entrance lobby of the

home. At the start of the inspection, the rating was not displayed on the provider's website, although a link to the CQC report was included. We raised this with the registered manager and by the end of the inspection the rating was correctly displayed on the provider's website.
• Notifications of significant incidents had been made to CQC, in line with the requirements of their registration. Additional condition imposed on the provider's registration following the last inspection had also been complied with. These included sending CQC monthly audits and notifying CQC when new people were admitted to the home.
• All staff were open and transparent during the inspection and managers were responsive to suggestions for improvement.
• Visitors told us they were always made to feel welcome and were offered drinks. One visitor told us, "We've even been invited to stay for lunch today."

Continuous learning and improving care
• The provider had engaged with the local authority quality improvement team, who were supporting staff to drive improvement. A family member told us, "We can see some changes; they are getting more specialised staff to look after residents." A social care professional said, "There have definitely been improvements. I have been pleased with them on the whole."
• The provider had also engaged with the Clinical Commissioning Group (CCG) infection control lead. They had visited the home and made suggestions for improvement, which we saw had been implemented.
• Plans were in place to further enhance the service by introducing more staff 'champions' to take the lead on key aspects of the service, including: safeguarding, infection control and oral care.

Working in partnership with others
• The service worked in collaboration with all relevant agencies, including health and social care professionals. A professional from the CCG told us the service had been "very responsive" to all their suggestions for improvement and had accepted all their advice.
• A commissioner of services told us, "They [staff] have involved all the relevant professionals [to support the person], for example, she is seen frequently by the community mental health service, there is a good link with them." Another commissioner of services said, "[The managers] are very approachable and respond to my queries in a timely manner."
• Through links with the community nursing service, some staff had received training in "the factors affecting wound healing" which had enhanced their understanding of pressure area prevention and treatment.
• Other links had been developed with local community groups that benefited people. These included a learning disability group that visited three times a week to use Bluewater's facilities and to interact with people; for example, they had joined people for an ice cream and waffles afternoon and served afternoon tea to people on another day.
• Family members told us this group was well-received by people. The registered manager told us they each enjoyed the others company, which they found mutually stimulating. This was confirmed by the group leader, who also praised the initiative.
• Exchange visits were made with another local care home and the registered manager told us of plans to extend "the opportunity of meeting new people, building new friendships and encouraging social interaction".
• Links had been established with a primary school and two nursery schools, whose children visited regularly to interact and enjoy activities with people.
• Staff also involved people in fund raising events for local charities. A family member told us these events created a "happy, busy atmosphere". In recognition of their fund-raising efforts, several people had been invited to the Lord Mayor's parlour for high tea, which would fulfil a wish that had previously been expressed by one person.

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 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to maintain accurate, complete and contemporaneous records in respect of each service user's care and treatment and of decisions taken in relation to the care and treatment provided. Regulation 17(2)(c). |