Barchester Healthcare Homes Limited

Bloomfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Bloomfield on 16 August 2016. When the service was last inspected in March 2015 there was one breach of the legal requirements identified. We found that people were not fully protected against the risk of unsafe or inappropriate care and treatment as records were not accurately maintained. In addition to this we found that although the provider had governance systems, these were not consistently effective.

The provider wrote to us in May 2015 to tell us how they would meet the requirements of this regulation. During this inspection we found the provider had again failed to achieve full compliance with this regulation. In addition, we found an additional three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

Bloomfield provides accommodation for people who require nursing or personal care to a maximum of 102 people. At the time of our inspection 84 people were living at the service.

A registered manager was in post at the time of inspection. They had registered with the Commission in July 2016. 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.

The provider had not ensured people's medicines were managed safely. In addition to this, we found that where people had an incident or accident, insufficient action or management level reviews had been completed to minimise future risks to people. There were insufficient systems to ensure people were being lawfully deprived of their liberty. We found that Deprivation of Liberty Safeguard (DoLS) authorisations were out of date. DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. In addition to this, the provider was not always providing care in line with people's consent and with mental capacity legislation.

The provider had not introduced robust systems since our last inspection to ensure that staff maintained accurate records of people's care, placing people at risk of unsafe or inappropriate care and treatment. The service did not consistently deliver appropriate care that met people's needs. There was no system that ensured people living in isolated areas of the building were regularly checked and some air mattresses were incorrectly set which may have had an adverse effect on people's health and well-being. We found that pain management was not always effectively monitored. There were insufficient robust governance systems to ensure people's clinical and non-clinical needs were met safely. The provider had failed to send a legal notification as required.

We received mixed feedback from people in relation to staffing levels at the service. Most staff commented that staffing numbers were sufficient, however they commented they did not feel the provider's staffing tool

was accurate. People we spoke with told us that generally there were enough staff but we did receive some negative feedback. The service was clean and checks of the environment and equipment were completed. Staff understood their obligations in relation to safeguarding adults and recruitment procedures were safe.

Staff were supported through training and the provider had an induction aligned to the Care Certificate. The service management were currently implementing regular supervision and appraisal. People were supported by staff that understood the principles of the Mental Capacity Act 2005 in relation to offering people choices. Where required, people were supported to eat and drink and the feedback we received about the food was positive. People could access healthcare professionals when needed.

People told us staff at the service were caring and we received positive feedback. People were treated with dignity and respect and we observed staff communicating with people in a caring manner. Staff understood the needs of the people they cared for and people's preferences were recorded to help support staff in delivering person centred care. There was a range of activities people could partake in and people were enjoying activities on the day of our inspection. The provider had a complaints procedure in operation.

The service management had systems to communicate with staff and staff felt able to raise ideas and suggestions. Staff were positive about the management of the service but commented negatively about the number of management changes they had experienced. There were clinical governance meetings and systems to record people's needs, together with a system to monitor the quality of service provided.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were not managed safely.

Incidents and accidents were not investigated to reduce risks.

We received mixed views in relation to staffing levels.

People had risk assessments completed.

Staff recruitment was safe and staff understood safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service was not meeting the requirements of the Deprivation of Liberty Safeguards.

Best interest decisions had not been completed when required.

People were effectively supported with their nutritional and hydration needs.

Staff received regular training and supervision was commencing.

People could access healthcare professionals where required.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff that provided their care.

People were treated with dignity and respect.

We observed positive relationships between staff and people living at the service.

The provider encouraged feedback about the service.

Staff understood the needs of the people they cared for.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

Records for people and the management of the service were not always accurate.

People's needs were not always met by staff.

People's preferences were recorded and people complimented staff.

There were activities for people to partake in.

The provider had a complaints procedure and people and their relatives felt able to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

Governance systems to monitor the welfare of people were not effective and placed people at risk.

The provider had failed to send a legal notification as required.

Staff spoke positively about the new management team.

There were systems to communicate key messages to staff and staff felt able to contribute.

There were some effective clinical governance and quality assurance systems in operation.

Bloomfield

Detailed findings

Background to this inspection

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

This inspection was carried out by three inspectors, a specialist nurse advisor 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. When the service was last inspected during March 2015, one breach of the legal requirements was identified.

Before the inspection we reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the home were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us. We also looked at nine people's care and support records.

We spoke with 21 people who used the service, five people's relatives and spoke with 12 members of staff. This included the registered manager and the deputy manager. We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Inadequate

Is the service safe?

Our findings

People were not fully protected against the risks associated with medicines. We identified multiple concerns in relation to the storage, management and administration of medicines. The service was not following best practice guidance (National Institute for Health and Care Excellence guideline SC1) or as per the provider's medicines policy. Due to the impact some of these concerns on people, we immediately brought them to the attention of the provider's practice development nurse and other senior staff to allow them to take immediate action.

People had not received their medicines as prescribed. On the day of the inspection we reviewed medicines and found one person had not received an antibiotic that been prescribed for the past seven days as the service did not have it in stock. This was immediately highlighted to the nurse on duty, who was not aware the person needed this medication. The nurse then contacted the pharmacy to arrange immediate delivery.

Medicines Administration Records (MARs) are used to record the administration of prescribed medicines. We found recording omissions on several people's MARs. This meant we were unable to establish if a person had received their medicine on this day. These omissions had not been identified by the responsible nursing staff until they were highlighted by us during the inspection. Prior to our inspection an incident occurred whereby 11 medicines had been omitted by an agency nurse. This included medicines for peoples Parkinson's disease and hormone medication which should not be stopped abruptly. This had not been recorded as a significant incident or informed to people's relatives or their GPs. This meant a full review could not be undertaken and learning shared to reduce the risk of reoccurrence. We also found stock monitoring completed on the MAR on a daily basis was not accurate for some medicines.

Controlled Drugs (CDs - medicines which are at higher risk of misuse and therefore need closer monitoring) were not managed safely. During our inspection, we established a significant incident whereby the service had failed to respond appropriately to the theft or loss of a CD. We identified a discrepancy in the stock levels of a CD. Following direction from the inspection team, the matter was reported to the appropriate authorities including the police following the inspection. We reviewed three topical administrations records for CDs. These were not always completed comprehensively; they did not record where pain relieving patches were applied, on the person's body. This made it difficult for staff to ensure that the patch application sites were rotated.

The storage and administration of medicated and non-medicated creams was not safe. We found discrepancies in the administration of a medicated analgesic (pain relief) cream, which had resulted in a person not receiving their medicated creams as prescribed. Many creams had no date of opening recorded on the label. This meant that some people were at risk of receiving creams which should have been disposed of as they had exceeded the safe storage guidance. Some people were currently receiving creams and staff were unable to tell us whether the cream was 'in date' or not. We found one cream in a person's room that was unlabelled but in use. It was impossible to identify who this cream had been dispensed for. Not all people had topical MARs in their bedrooms to inform staff where and how often to apply the creams. Where they did have these MAR, they did not always contain sufficient information for the cream or ointment

to be applied correctly. For example, one record stated, 'Apply twice a day' but gave do directions on where to apply the cream.

Temperatures for the medicines refrigerator were not always recorded daily. The temperature of one medicines room was at the maximum recommended temperature on the day of the inspection whilst the room door was open. We could not be assured medicines were stored at the correct temperatures which is important in ensuring they are fit for use. We also found that some items within refrigerators had not been dated when opened.

We found that senior management had not done all that was reasonably practicable to mitigate or reduce risks to people following an incident or accident. Incidents and accidents were recorded by staff on the appropriate form. This detailed what had happened and any immediate action taken. Staff told us these forms were then handed to management. However, we found that the rest of the form was rarely completed. The form should have contained additional information on who was the senior staff in charge at the time, any subsequent action taken, changes made to prevent reoccurrence, any investigation needed and any other people or agencies that needed to be informed. This could include family members, the local safeguarding team or the Commission.

We found that of the 53 incident and accident reports from 1 June 2016 to 12 August 2016, only 11 had been fully completed by senior staff or management. This meant that incidents such as unexplained bruising or missing medicines had not been fully investigated and no actions had been recorded as being taken. One staff we spoke with said, "We are always told to report everything in as much detail as possible. But I don't know what happens to the reports when we hand them in." One example showed an incident in July 2016 where a person had spilt hot tea in their lap. No first aid was recorded as being given. No follow up had been completed to establish how this had occurred and any changes that could be made to reduce the risk of this incident happening again. We did see the person's injury (redness on legs) was recorded in their daily notes and monitored. This meant that people were at risk as serious incidents were not being investigated or any action being taken to eliminate or reduce the risk of reoccurrence.

All of the above information is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, one of the inspection team inspected four bed rails in conjunction with the Barchester Practice Development Nurse (PDN). Measurement of the height of the bed rails above the mattress indicated they were not compliant with the Health and Safety Executive (HSE) guidance relating to bed rails. The completed bed rail risk assessment for one person had been incorrectly completed to verify that the bed rails were of the correct height, yet the risk assessment did not contain any guidance relating to the appropriate height measurements. The bed rails were not compliant with HSE guidance, they were not high enough to reduce the risk of the person rolling over the top of them. Once this was highlighted, the PDN immediately contacted the relevant colleagues to try and rectify the current low heights of the bed rails.

We received a mixed response from people, their relatives and staff when we discussed the staffing levels at the service. Staff told us they had concerns about staffing levels in the home. One member of staff said they were told by managers the staffing was in accordance with the DICE tool, which is an internal tool used by the provider to calculate staffing levels following an assessment of people's needs. The member of staff told us, "The DICE tool just doesn't work." Other comments included, "We're often short at weekends. There's no management around and skeleton housekeeping staff." "We struggle sometimes to get the care done and there's no time for the extras." Another staff comment we received was, "We're like a happy family here, but

we are a bit short (of staff) at the moment."

We saw examples of where staff deployment had not ensured people were always safe and people's needs met. For example, a relative we spoke with commented they didn't see staff very often. At 4pm on the day of the inspection, we observed the person's lunch that had been partially eaten was still in their bedroom. The relative told me they thought this was because the person's room was at the end of the corridor and staff didn't pass by very often. They said this was not a complaint, just an observation. They told us they thought the care staff were really nice. We observed there were two white oval tablets on the bedside table, in front of the person who was asleep in the chair. The relative told us the person had spat out the tablets when the nurse left the room. This was from the lunch time medicine round. We took the tablets to a senior clinical support manager who told us they would look into the issue.

During our conversations with people and during observations, we observed that at times people living at the service received a different level of staffing support depending on which area of the service they lived in. For example, we made observations in Ashway that people's needs were met and people told us they were happy with staffing levels and usually had the same regular staff. However within Salisbury Rise we observed people sitting in the lounge unattended for long periods of time and there appeared to be less staff visible on this unit. Many people were cared for in their rooms and call bells were heard ringing for long periods.

People's comments varied throughout the service. For example, on Ashway someone told us, "(I am) Absolutely safe, carers are passing and checking all the time." On Salisbury Rise someone commented, "I can walk around without fear, there are staff around but not always enough for others." Another person on Salisbury Rise said, "They (staff) are run off their feet, they need more at times."

We spoke with the management at the service about current staffing levels. The management told us that although the DICE tool was being used, additional staffing numbers above the DICE recommended level were currently being deployed. We were told that the service had just recruited 19 staff but still had eight nurse vacancies and between six and nine care staff vacancies. The registered manager told us that agency staff use has gone down and said they used regular agency staff members who knew the service. Staff told us that the Ashway and Salisbury Rise units relied more heavily on agency staff than Beech Walk and Mendip View. We were unable to assess if the service had achieved their minimum staffing levels as they were not set.

People and their relatives were positive about the service they received. Many of the comments we received during the inspection were positive about how people felt safe and the staff that supported them. For example, one person commented, "I chose to come here, because it is close to where I lived and I had visited other people here and knew that it was a safe haven. It is like a hotel here, I feel safe and comfortable." Another person said, "I am settled here, it is lovely here, I am well looked after." One person's relative said, "My [service user name] is definitely safe here, their mood has lifted since being here, happy with everything."

Individual risk assessments identified potential risks to people and gave guidance to staff on how to support people safely. Assessments included risks such as eating safely, personal care and falls. For example, we reviewed an assessment detailing how a person was unable to use the call bell in their room and the monitoring staff needed to undertake to ensure the person was kept safe. The risk assessments were reviewed monthly. However, we found the record of actions taken were not always consistent or in accordance with the care plan to reduce risks. We have reported on this in more detail within the 'Responsive' section of this report.

We found the service was clean and domestic staff were employed daily to maintain standards of cleanliness. There was liquid anti-bacterial gel available at the entrance of the building and we made observations that staff wore personal protective equipment such as gloves and aprons when required. The registered manager had an auditing system to monitor the cleanliness and safety of the environment. No concerns were raised by people or their relatives in relation to the cleanliness of the service. During our visit, one of our inspection team did highlight to the management of the service that a commode within one person's bedroom was soiled and required cleaning. This matter was addressed as soon as the matter was identified.

There were appropriate arrangements to identify and respond to the risk of abuse. A safeguarding and whistleblowing policy were available for staff that gave guidance for staff on the different types of abuse, and what action should be undertaken by staff should they be concerned for a person's welfare. Staff we spoke with demonstrated an understanding about safeguarding and explained reporting procedures both internally within the service and how to report concerns externally to the Commission or local safeguarding team. One staff member said, "It is about keeping people safe. I would report to the senior on duty and make sure my concerns are recorded." Staff told us they had received training in safeguarding which was confirmed by supporting records. Staff were familiar with the concept of whistleblowing to report poor practice and how they could contact external agencies in confidence if they had any concerns.

The provider had systems that monitored the environment and the equipment within the service. There were systems that monitored the maintenance of the service in relation to hoists, slings and other mobility equipment such as wheelchairs and specialist bathing equipment. The nurse call bell system was serviced to ensure it was serviceable and regular water temperatures were completed. There was fire folder that showed emergency evacuation plans for people and we saw supporting records that showed the fire alarms, emergency doors and lighting were regularly checked and tested.

The provider operated safe recruitment procedures and ensured all pre-employment requirements were completed. Staff files had completed initial application forms together with the staff member's previous employment history and employment or character references. Photographic proof of the staff member's identity and address had been obtained. An enhanced Disclosure and Barring Service (DBS) check that ensured the applicant was not barred from working with certain groups such as, vulnerable adults had been completed.

Requires Improvement

Is the service effective?

Our findings

The provider had not always met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). 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 were being met.

The registered manager had no clear system to oversee when DoLS applications had been authorised, when they expired and if they had any attached conditions that were required to be met. We found that two people's DoLS authorisations had expired and had not been renewed in June 2016 and July 2016. We found an additional three authorisations that had been renewed when the registered manager investigated, but there was no recorded information to show this and when the authorisation now expired. In addition to this, during our conversations with staff not all were able to explain what the DoLS legislation meant. Staff were also unaware of who in the service was subject to a DoLS which could place people at risk of inappropriate care. One staff member said, "No, I'm not aware who has a DoLS." Another member of staff commented that they thought, "Everyone in the home is under DoLS."

This was a breach of Regulation 13 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.

During a review of people's care records we found inconsistency in the application of the MCA in relation to restrictive practice. Consent had not always been recorded to show that people had agreed to having their photographs taken for medical purposes. For example, within care records we found capacity assessments had been completed for the decision to live at Bloomfield. However, we found that where people did not have the capacity to consent, the capacity assessment stated who had been involved, but did not always provide detail of specific decisions the person could make or be supported to make. The checklists we saw were completed for people, 'To live at Bloomfield and to receive care and treatment.' One person's best interest decision stated, 'Appears settled and in best interest to be here.' This did not show a decision making process had been followed, showing what specific decisions had been made in relation to the person's care or treatment and why they were in the person's best interests.

We observed that one person was nursed in a recliner chair had no evidence of consent to this or a best interests decision having been taken in relation to its use. This meant there was no supporting evidence to

demonstrate why being nursed in a recliner chair (restrictive due to the person being unable to move from the chair) was in their best interests. Additional examples of best interest decisions not being taken related to people having bed rails fitted which is also restrictive. We also found that where a person had their medicines covertly (without their knowledge) administered by staff there was no supporting best interest decision paperwork. When medicine is administered in this manner, there is a requirement that the service demonstrate why the decision had been taken to administer the medicines in this way and why it was in the person's best interest.

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

People and their relatives spoke highly of the effective care provided by staff at the service. People spoke highly of the care they received and told us they were supported by well trained and knowledgeable staff. One person we spoke with said, "(They are) Confident staff, they know what they are doing you can tell they are well trained." Another person told us, "I do not want for anything, they treat me right." A person's relative we spoke with said, "From my observations I think staff are very good, my [person's name] is very demanding and they deal with them well."

People had access to GP and healthcare professionals. Three GP practices supported the home. Each practice visited the home on a weekly basis, in addition to callouts as needed. They had quarterly meetings with the care home management team. The registered manager told us they felt well supported and that the GP's were approachable and supportive. People also had access to other healthcare professionals such a chiropodist and speech and language therapist where the need was identified.

Staff understood their roles in relation to The Mental Capacity Act 2005 (MCA). Staff told us they knew they had to obtain consent from people before they provided care. We also heard staff asking people, for example, "Would you like to go outside now." We also heard staff on many occasions speaking with people and starting their sentences with, "Is it alright if I?" or, "Would you like me to?" This also demonstrated they did things in line with people's consent and wishes. We saw within some care records that information was recorded such as, 'Able to choose clothing for the day when offered a choice.' During conversations with staff they demonstrated how they empowered people. For example one member of staff told us, "I show different outfits. I ask people the colours they would like to wear that day. Some people can point to what they would like, others can tell you."

The provider had systems in place to ensure staff received supervision and appraisal, however these had not always been utilised. Some staff we spoke with told us that although they felt supported in their roles, they could not recall when they last received supervision or appraisal. The registered manager and deputy manager had identified this shortfall since taking post and we saw that staff members who had not had supervision for the previous two months had been identified and listed. These staff members would shortly be receiving supervision and appraisal where necessary. We saw some evidence that a small number of supervisions had already been recently completed which demonstrated the management team had identified, and responded to the shortfall identified on their appointment.

There was a training schedule that ensured staff received appropriate training to carry out their roles. Staff felt they were given sufficient training to effectively support people and meet their needs. Staff had received appropriate training in a variety of relevant topics to meet the needs of the people. This included moving and handling, health and safety, fire and safeguarding. It was noted that staff had not received training in relation to some people's individual medical conditions to ensure they understood and could meet the person's needs. For example, staff commented on how they had provided support to a person with Motor

Neurone Disease for a considerable period of time but had not received training in the illness. Staff had also not received training in the application of creams or medicines. One staff member was very positive about their training and said, "The training is really good. Most of it is face to face training."

The provider had an induction process which encompassed the new Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were newly employed staff completing the certificate. Staff were further supported with progressive supervisions and observations through the initial stages of their employment. These were done to ensure the new staff member understood their role and were competent at providing care.

People were supported to eat and drink. People we spoke with were positive about the food they received. One person said, "Food is very good, get a choice, staff cut it up for me." Another told us, "Food is excellent, lovely today, always plenty." A further comment we received was, "There is always something you like, or you can have salad, I never go hungry - my best meal of the day is my bacon sandwich at breakfast, but I wish they would give us bigger cups of tea." People were referred to external health care professionals where required. For example, one person had a Speech and Language Therapist (SALT) referral and was visited in November 2015. Thickened fluids were recommended by the SALT and to be prepared to a 'syrup' consistency. We observed the person was drinking a suitably thickened drink in their room.

We found where people received support with liquid nutrition through a Percutaneous Endoscopic Gastrostomy (PEG) tube guidance was clearly recorded. For example, for one person with a PEG feed there was clear detail, guidance and instruction from the dietician and supplier of the PEG feeds nurse about the feed programme, equipment and how to support the person. This included possible side effects the person may experience when the type of feed was changed. The care plan provided detail about the care the person needed. We also observed that people were offered hot and cold drinks, biscuits and cake in between meal times. We also observed that jugs of squash were set out in the lounges on the morning of the inspection.

During meal times we observed that menus were available on each table and the choices were read to people. We observed meals were brought to people so they could see the choices and make a decision that way. The dining room tables were laid attractively with tablecloths and napkins. The food looked appetising and there were several choices. We saw that where required, provisions were made for people to meet their needs. For example, two people went to hospital for a medical procedure three times a week. Kitchen staff prepared a packed lunch for them to take with them, they had a hot meal when they returned later that night.

Good

Is the service caring?

Our findings

We received a range of complimentary and praising comments from people and their relatives when we asked them for their views of the staff and the care provided. The comments we received from one person were, "(I am) Happy with the way I am being looked after, I have nothing to grumble about." Another person commented, "Staff are kind and have a caring attitude." One relative we spoke with praised the service and said, "They treat my relative in a dignified way, they are lovely to me and the whole family too."

People felt respected by the staff at the service and told us their privacy and dignity was respected. People and their relatives commented on the polite and friendly nature of staff. All of the people we spoke with felt they were treated with dignity and respect and that their privacy was respected by staff. One person commented, "Staff shut the door and pull the curtains before they do my care, I feel comfortable with them." We made observations that staff knocked and waited for a response before entering people's rooms.

Care records gave guidance to staff about maintaining people's privacy and dignity and staff we spoke with were knowledgeable about this. For example one care record said, 'Close the curtains and shut the door when assisting with personal care.' One staff member said, "When we support people with personal care we always ensure the door is closed and the curtains are drawn." We observed a staff member place a blanket over a person's lap who had fallen asleep to ensure their dignity was maintained as their dress had ridden up.

Observations made by our inspection team demonstrated staff had a caring manner towards people. People were well dressed wearing clean clothing and tidy hair. From observing people's body language and facial expressions, they appeared to be comfortable when staff approached them, some showing obvious signs of affection. We observed members of staff, kindly and patiently reassuring a person who was concerned about a family member. This was done repeatedly, each time as if it was the first. With a person's permission, we observed staff using a hoist to transfer them from an armchair onto a commode. Staff were confident with the equipment and were conscious that the procedure caused some discomfort to the person. During the transfer staff gave encouragement and reassurance to the person.

We observed staff at lunchtime. Staff were happy, chatty and friendly with people. Staff made nice comments to people including, "You look beautiful today," and, "What a lovely dress you are wearing." Whilst people were waiting for their food to arrive staff went and spent time with different people asking them how they were, or talking about things they knew they liked. When people became distressed or anxious a staff member ensured they were reassured and comforted. Staff gave people individual time and attention. We observed when a person started to display behaviour that may be viewed as challenging, staff calmly reassured them and gave them space and then returned to support them. The staff member followed the strategy that was detailed in the person's care record.

Staff were attentive to people needs. One staff member said, "Would you like me to clean your glasses" as they could see the person's glasses were smudged. Staff respected people's choices. For example, one person said they did not want to sit at the dining table to eat. Therefore a smaller table was brought to

where they were sitting. Choices were offered to people, for example what people would like to drink. Staff were observed to be patient and helpful when a person was deciding. We saw staff knew how people could make their choices. For example, for one person the drinks choices were brought in front of them so they could point to what they wished to have. In addition to this, we observed people visiting the hairdresser who was in for the day. Staff accompanying them were kind and attentive to their needs. One staff member said, "Would you like a drink." The person replied, "Yes please - lemonade." Staff went and got their drink and then started a conversation about holidays and things the person had done. Staff were friendly and engaging.

The provider encouraged people or their relatives to use a national website to give feedback on the service. There was information about the website displayed in the main entrances to the service. The website only currently had one review which had been posted in May 2015. The review was positive and described all areas of the service including staff and care as either good or excellent. A comment from the review included, 'Mum has been at Bloomfield for the last 12 months and she absolutely loves it, she says the staff are brilliant. Mum was admitted on the end of life care and now one year on she has made a remarkable recovery which stems from the great nursing care she has received. When we visit we find all the staff from the receptionist to the carers and cleaners all very helpful and polite. The food is good and there is always some sort of activities for those who want to join in. I would not be afraid to recommend Bloomfield to anybody who wanted a good nursing care.'

Staff were knowledgeable about people's care and treatment needs. Staff understood personalised care and demonstrated this when they told us how different people liked to be cared for. This showed they understood the people they cared for. It was evident through our observations between people and staff that there were good, caring relationships and people always appeared relaxed and happy during interactions with staff. Staff comments showed a positive attitude towards promoting a good quality of life. One comment we received from a member of staff was, "I work here for the residents."

Requires Improvement

Is the service responsive?

Our findings

At the inspection of Bloomfield in March 2015, We found that people were not fully protected against the risk of unsafe or inappropriate treatment as records were not accurately maintained.

The provider wrote to us in May 2015 to tell us how they would meet the requirements of this regulation. During this inspection we found the provider had failed to achieve compliance with this regulation. In addition to a continuation of the breach we found at our last inspection, we found an additional breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inspection team found examples of record inaccuracy during our visit. This meant that we were unable to establish if care had been provided in accordance with people's assessed needs. This also meant that should staff or management of the service need to establish if people's needs were met at a particular time, they would be unable to do so. This continued to place people at risk of unsafe or inappropriate care or treatment. In addition to this, comprehensive records on how to meet people's needs and guidance for staff on how to achieve this were not consistently completed.

For example, within one person's records we saw that on 10 August 2016 they were referred to a Tissue Viability Nurse (TVN) for a grade 2 pressure ulcer. The person's care plan stated the person should be repositioned every 2-3 hours to support them. If following this direction correctly, this meant the person should be repositioned between eight and 12 times a day. We reviewed the person's records that stated the frequency repositioning had been completed. On 12 August 2016, there were 7 records showing repositioning had been completed, on 13 August 2016 there were six entries, on 14 August 2016 there were five entries and on 15 August 2016 there were six entries. On the day of the inspection we checked this person's repositioning record at 3.40pm and the record had not been completed since 8.50am that day. In addition to this, the person was prescribed a cream to be applied 3 times a day to dry skin areas. This topical medicine was recorded as administered once a day on the topical MAR. The person's care plan also stated they should be, 'Encouraged to drink 1.5litres per day'. The person's fluid intake was not monitored or recorded.

Within a care record we found poor record keeping around the use of suction equipment (used where needed to ensure people have a clear airway to optimise respiratory function). For one person, we found a mouth care record was in place. This was not completed on 9 or 13 August 2016, and the person was noted as having refused care on 11 and 14 August 2016. A note on the chart stated 'suction' but nothing further. A 'Post It' note (loose yellow sticky piece of paper) in the care file dated 7 June 2016 stated, 'choking on saliva.' But again, there was no further information about any intervention taken or additional support given. This was subsequently discussed with a registered nurse on duty who told us they did not think suction had been used, but there were no records in the care plan that could confirm the use or non-use of suction.

Within another care plan we saw poor records relating to suction. The person's daily notes dated 8 August 2016 stated, 'Coughing a lot today, tried to tap his back but [service user name] hitting out. Tried to suction but [service user details] also became challenging.' There was no further detail about how the person was

challenging. The care plan confirmed the person had chest infections on occasions. There was no care plan about the use of suction if needed. Following this, we checked the suction equipment. Two nurses on duty had stated the suction equipment was ready to use in the event of an emergency situation. The equipment was not ready to use. There was no catheter tubing with the equipment and the nurses did not know where or if there was any tubing in the service. This meant the service may not have been able to respond in an emergency situation.

In addition to these records, we found that records relating to the management of the service were not always completed accurately. For example, a 'Pressure Damage Safety Cross' was used to complete a monthly assessment of people who had a pressure ulcer. From reviewing the completion of this assessment, we found that no record at all had been made for January 2016 and recording omissions had been made in March 2016 and April 2016. From reviewing the 'Night staff checklist' we saw that some records were incomplete so it was not possible to establish if some tasks, such as changing food and fluid charts or checking mobility equipment had been completed. We saw that daily care reports were missing fully completed records during July 2016 and August 2016.

We further established that an incident had occurred on 28 December 2015 between two people living at the service where one had struck the other. The person's family member had made a complaint about this. The incident form in relation to this could not be found when we requested it. During the inspection the registered manager searched for the incident form and any associated documentation and it could not be located. Therefore we could not find the full details of what had occurred and if the complaint was responded to appropriately.

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

The service did not consistently deliver appropriate care that met people's needs. For example, there was no system in place to regularly check the safety of people in communal areas. One person's records stated they needed to be checked regularly when they were in the lounge. They had been assessed as at 'low risk' of falls. Another entry in their care plan noted, 'Moves into unsafe positions which could lead to falls' and for staff to, 'not leave him on his own.' There was no record of the times that he was monitored during the day. The activity coordinator spent time with the person on a couple of occasions, and I saw the person was outside in the garden (with a relative) during the afternoon and then in another lounge later during the day to watch television. We spoke with the registered manager who told us the person was checked regularly and they commented, "There is always staff around the lounges to check him." This was not so. We completed an observation and spent approximately 45 minutes in the lounge during the morning and we did not see the person being checked. Staff walked through the lounge and the hostess laid the tables for lunch. We did not see the person being checked. We had to find staff for another person who was sitting outside. They had called out for staff three times over a five minute period. We found a member of maintenance staff who told us they would find a member of staff.

We found that where people had an air mattress to support them with lowering the risk of developing a pressure ulcer, these were not always operating at the required level. A number of people had non-auto regulating pressure relieving mattresses in place on their beds. If pressure relieving mattresses are set correctly it can help to prevent the development of pressure ulcers. However, if the mattresses are set to the incorrect setting they can have the opposite effect. One person had a pressure relieving mattress in place on their bed, yet there was no reference to this in their care plan. There was no reference to the correct setting in the person's care plan or documentation. The pressure relieving mattress had been set incorrectly at 10kg more than the person's weight. When asked about monitoring of pressure relieving mattresses, one

member of staff told us, "We used to have a form for that. I'm not sure how they're checked now."

People's individual needs in relation to pain management were not consistently met. We checked the records and support for one person who was receiving end of life care. Throughout the day the person looked uncomfortable and made noises that suggested they were not comfortable or they were in pain. The GP had assessed the person the day prior to our inspection and pain relief had been changed and specific medicines had been prescribed to support the person at this stage of their life. We established the person was suffering pain in a specific area of their body. The person's current care plan referred to pain the person had previously experienced in different areas of their body and no reference was made to the current pain site. There was no pain monitoring tool or pain assessment in place. This meant the person's pain was not accurately assessed and their pain may not be effectively controlled.

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

People and their relatives spoke highly of the staff and told us their needs were met. We received positive comments about how staff met people's needs and people told us they were satisfied. One person commented, "Staff are very friendly, they look after me well. They have a very good caring attitude." Another person told us, "Staff get on with it, they have been doing it for so long. Staff see to it if you are unwell and get a doctor." One person's relative said, "They are definitely caring. They found a bed for my relative on the ground floor when they knew my relative smokes, and they take my relative out into the garden to have a cigarette."

Care records contained personalised information about people. People were assessed before they moved into the home. Risk assessments and care plans were completed. The care records provided detail about relative's involvement. There was a current photograph of people and essential information about their life history. This described people's background, interests and family members. Personal preferences were evident throughout people's care plans. For example, in one person's record it said, 'Likes to go to bed about 7pm.' People's preference over being supported by a male or female carer was included. Staff we spoke with showed they knew this information. One staff member said, "[Name of person] only wished for female carers. Over time this changed and this was reflected in her care plan."

Care records also contained details on people's preference in regards to food and drink. They included a list of people's likes and dislikes. For example, likes coffee and gin but not keen on puddings. Information was also detailed about how people preferred to communicate. For example one care record said, 'Can express herself verbally and have a full conversation.' Staff we spoke with showed they knew people's preferred method of communication. We saw an example of good record keeping when explaining a person's communication needs. A person who required support with liquid nutrition had a detailed care plan in place. This included how the person was able to communicate using nods or shakes of the head and hand gestures. A pain assessment was completed and confirmed the person was able to point to an area if they were in pain.

We saw that reviews of people's care had taken place and key people had been invited to attend, for example people's family members. We saw that people were involved in their care review. One person's review said, '[Name of person] said she is very happy and settled here.' A monthly summary was completed. This summarised any significant information for example if a person had any falls and if any changes had been made to risk assessments.
People and their relatives felt able to complain or raise issues within the service. The service had a complaints procedure. We reviewed the complaints record within the service and spoke with the registered

manager about the current complaints. The service had received seven complaints since January 2016. We saw that complaints had been investigated and a response given to the complainant in line with the providers policy and timescales. Where action was needed and had been taken, for example, the purchasing of additional equipment, this had been recorded.

A range of daily activities were available for people to participate in. The home had a dedicated activities staff to support people in recreation. The registered manager told us that activities staff were currently employed over six days of the week. There were different dedicated activities areas within the service and we saw that when an activity was held in one area of the service people living in other areas were invited. There was a weekly activity schedule printed that showed activities such as flower arranging, home baking, crafts, songs of praise and Tai Chi were arranged. On the day of our inspection we saw that people had the opportunity to take part In a game of skittles in the morning and in the afternoon a BBQ was held in the garden.

Requires Improvement

Is the service well-led?

Our findings

At the inspection of Bloomfield in March 2015, we found that the provider had not ensured clinical governance systems were used effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider wrote to us in May 2015 to tell us how they would meet the requirements of this regulation. During this inspection we found the provider had failed to achieve compliance with this regulation. In addition to a continuation of the breach we found at our last inspection, we found the provider had failed to send a legal notification to the Commission as required.

There were some auditing systems in operation. However, these were not robust and these audits did not have the detail or depth to identify the shortfalls in relation to record keeping or care planning we identified during the inspection. For example, there was a daily care report completed that recorded who was the 'Resident of the Day' and ensured the providers staffing level assessment tool had been completed. The deputy manager had completed a daily audit when they were working that included walking around the service, discussing clinical issues with senior staff, visiting ill people and checking fluid charts. These audits did not focus on if care documents were completed correctly or if people's care records reflected their current needs.

Although the 'Resident of the Day' system checked documentation, this was not done by senior management and it did not encompass monitoring for recording omissions by staff. We saw records that showed there was a documentation audit completed, however this audit was done shortly after admission to the service to ensure all the correct documentation was within the person's file. There were no on-going record monitoring systems to ensure care files and records were monitored following this. This placed people at risk as it did not demonstrate their health, safety, welfare or care delivery was being effectively monitored.

There was no current system that ensured records relating to the clinical needs of some people were effectively monitored by senior management. There was a clinical governance audit completed. This ensured the service recorded who had clinical needs, for example a pressure ulcer, any skin tears or weight loss. This information was then sent to a member of the provider's clinical team. However, this audit didn't establish if the daily clinical records relating to these people were correct and if their clinical needs had been met in between the monthly audit periods. There was no review of the records that staff had completed within this audit. An audit of this depth would have identified the recording omissions we identified.

From reviewing medicine audits we found that these were ineffective. A weekly management check of medicines was due to be completed, however we only found audits that had been completed once in June 2016 and August 2016. These audits were to ensure the clinical room was locked, Medicine Administration Records (MAR) were completed correctly, the stock balances were correct and that medicines had been received and disposed of correctly. Due to the significant errors and shortfalls we found with medicines management, as reported in the 'Safe' part of this report, it was evident this audit had not been completed accurately or effectively. The records did not make any reference to the unsafe practice with medicines we identified during the inspection.

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

The registered manager had failed to notify the Commission of an incident as required. During our inspection, we found a found a significant incident involving a controlled medicine had occurred at the service prior to our inspection. The service had failed to report this matter to the police and any other relevant regulatory bodies. The matter should have been reported immediately to the police and a notification required by law sent to the Commission. This had not been completed. The registered manager told us this matter would be addressed immediately following the inspection.

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

The registered manager had received some support from the provider since assuming post. However, these had only commenced in July 2016 and at the time of our inspection there had only been two support visits completed since the new registered manager had assumed post. These focussed on the presentation of the home and welcome documentation. The presentation of people at the service and interactions with people was also reviewed together with an observation conducted of people's mealtime experience. We saw that where these audits had identified actions, for example the installation of bathroom cabinets, an out of service fridge being removed and care plan updates this had been completed. There were no other records indicating that the new registered manager had received additional provider level support since assuming post.

Messages were communicated to staff through meetings. Different levels of meetings were held frequently at the service. For example, meetings involving all general day staff were held that discussed matters such as record completion, mobility equipment, meal times, cleaning schedules, people's bedrooms and staffing. Additional meetings were held for night staff that discussed observational charts, feedback received from agency staff and the expectations of night duty staff and their schedules. The meeting minutes also showed the registered manager had been proactive in these meetings by ensuring that any recent complaints received from people and their relatives were communicated. This meant all staff were aware of the nature of the complaints and how the service would react to reduce the chance of the matter happening again.

Staff feedback about the new management at the service was mostly positive. The new registered manager was described by one staff member as, "Firm but fair." Other members of staff we spoke with described the registered manager as "Lovely," "Open," and one commented that the registered manager, "Listens." Another staff member told us they felt the new registered manager was, "Doing a good job." Other staff commented on the current positive communication stating, "We have a handover. It is both verbal and written. I am notified of any changes when I come on shift. For example, if someone now has a sensor mat now in place." Another staff member said, "We have regular staff meetings. These are usually monthly. We can come forward with ideas." One staff member commented positively in that they now had staff and senior care staff meetings. They told us there had been so many changes of management over the years, and changes made, which changed again as the manager's changed.

There were clinical governance meetings held to communicate and collate information about certain people's care and support needs. For example, these meetings recorded information relating to which people were on a modified consistency diet, if the person had suffered a weight loss or had gained weight and if any new people had been admitted to the service with a malnutrition risk. In addition to this, quarterly meetings were held with GPs who supported the service. These meetings discussed matters such as recent deaths, medication or safeguarding issues, any recent hospital admissions or other significant events that had happened at the service. This ensured key information was communicated to relevant healthcare

professionals.

The service had a 'Resident of the Day' scheme in operation to ensure people were happy with various different aspects of their care and support. For example, the nominated 'Resident of the Day' would be visited by various different departments throughout the service. For example, somebody from maintenance would visit to ensure people were happy with their room, a chef would visit to ensure people were happy with the meals provided. A member of the activities staff would ensure people were satisfied with activities and housekeeping staff would ensure the person's room was at a cleanliness standard that was satisfactory. The person would also be visited by care staff and a nurse to ensure their care and support needs were met. We saw from records that this had resulted in care records and preferences being updated.

People and their relatives had the opportunity to attend meetings to find out key information about the service and contribute their thoughts. The new registered manager had held meetings with people since they assumed post in April 2016. Within these meetings we saw that matters such as staffing and staff continuity, the use of agency staff, activities and upcoming events were discussed. In addition to this we saw that people had also been able to express their views of the current staff and also that the recruitment and use of volunteers was discussed.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission, as required, of an incident reported to and investigated by the police. Regulation 18(1)(2)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of people was not always appropriate or did not meet their needs. Regulation 9(1)(a) and 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not always providing care in line with people's consent and with mental capacity legislation. Regulation 11(1) and 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Treatment of disease, disorder or injury	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not done all that was reasonably practicable to mitigate risks to people following an accident or incident. Regulation 12(1) and 12(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured Best Interest processes had been followed or taken ensured people were not being deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13(1) and 13(5)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were managed properly and safely to ensure people's needs in relation to medicines were met. Regulation 12(1) and 12(2)(g).

The enforcement action we took:

We served a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured clinical governance systems were used effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had not ensured records relating to people or the management of the regulated activity were accurate. Regulation 17(1), 17(2)(b) and 17(2)(c).

The enforcement action we took:

We served a Warning Notice