Bluebell Place Limited

Bluebell Nursing & Residential Home

Inspection report

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Date of inspection visit:
24 June 2019
25 June 2019

Date of publication:
25 September 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bluebell Nursing and Residential Home is a residential care home providing personal and nursing care to people aged 65 and over. At the time of the inspection there were 68 people living at the service. The service can support up to 80 people.

The care home accommodates people in one adapted building. The care home accommodates people across three separate floors, each of which has separate adapted facilities.
The ground floor unit caters for people who require residential care. The first floor unit provides accommodation for people with nursing care and complex needs. The second floor specialises in providing care for people living with dementia.

People's experience of using this service and what we found
Not all risks for people using the service were identified and staff's practice did not ensure people's safety and wellbeing. Though people and their relatives told us there were not always enough staff available, staffing levels were appropriate during both days of inspection. Further action was still required to make sure the premises was clean.

Not all staff employed at the service had received appropriate training or felt their induction was robust. Staff supervision and support was not consistent since January 2019. Though people received enough food and drink, the dining experience across the service was variable. The service monitors people's healthcare needs but not consistently follows-up on issues identified. The premises meets people's needs but improvements are required on the Memory Unit on the second floor to comply with the Accessible Information Standard.

People and relative's comments about the quality of care received was variable across the service. Our findings suggested people were not always treated respectfully. Staff do not sit and talk with people for a meaningful length of time or always explain things clearly.

Though each person had a plan of care detailing their care needs and how these were to be met by staff, shortfalls were identified in the information recorded. People's end of life care plans were poorly completed and not all staff were aware of who had been assessed as requiring end of life care support. People are not always supported to follow their interests or to take part in social activities. The service is not fully compliant with the Accessible Information Standard to ensure it meets people's communication needs. There was a low incidence of complaints and people were assured any concerns voiced would be listened to and actioned.

Governance arrangements were not reliable or effective and improvements were required.

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

The last rating for this service was requires improvement (published November 2018) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough, improvement had not been made and the registered provider was still in breach of regulations.

The service remains rated requires improvement. The service has been rated requires improvement for the last two consecutive inspections.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the Local Authority to monitor progress. We will 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.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bluebell Nursing & Residential 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 team consisted of two inspectors and an assistant inspector. An Expert by Experience accompanied the inspectors on both days of the inspection. 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
Bluebell Nursing and Residential Care 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.

Prior to the inspection the registered manager resigned their post. The service did not have a manager registered with the Care Quality Commission. However, the registered provider had appointed a new manager from within the organisation. They had been employed by the registered provider for the past seven years and had been the service's compliance manager. This means that they and the registered provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection and sought feedback from the Local Authority. The registered provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 12 people who used the service and 14 people's relatives about their experience of the care provided. We spoke with 12 members of staff including qualified nurses, team leaders, care staff and the person responsible for facilitating social activities. We also spoke with the newly appointed manager and the registered provider's consultant.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 10 people's care records and multiple medication administration records. We looked at five staff files in relation to recruitment and staff supervision records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

At our last inspection the provider had failed to ensure the premises were clean and hygienic so that people were protected from the risk of infection. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Although the premises were now clean and hygienic, not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.
Assessing risk, safety monitoring and management
• 11 freestanding wardrobes did not have a retaining bracket to prevent the furniture from falling, or being pulled forward with a potential to cause significant injury and harm. The manager and consultant were advised that a review of all rooms where wardrobes were located required appropriate remedial action taken to ensure peoples' safety and to mitigate any such risks. On the second day of inspection work was commenced to make people's wardrobes safe. We asked the manager and consultant to notify us in writing once the works were completed but to date the Care Quality Commission has not been informed of the progress made.
• Though most staff had received manual handling training, inspectors observed five separate incidents where staff performed unsafe manual handling practices. All of these related to the Memory Unit and referred to staff either placing their hands under people's armpits when assisting them to mobilise or pulling people across the floor from one location to another whilst the person remained seated in a chair. One person was observed to be lifted from the floor by staff following a fall and placed in a wheelchair. All techniques are unsafe as they can hurt and cause injury because the person's armpits and shoulders have too much pressure on them or place people at risk of falling from their chair to the floor. Staff did not recognise the above as poor practice.
• Not all risks for people were identified. Where risk assessments were in place, these did not clearly identify how risks to people's safety and wellbeing were to be reduced and the actions required to keep people safe. For example, the care plan for one person made reference to them having swallowing difficulties and at risk of choking and aspiration. No information was recorded detailing how the person was to be supported by staff and the risk to their wellbeing and safety reduced.
• On the first day of inspection we requested to see the service's 'emergency grab bag' which contained an individual PEEP [Personal Emergency Evacuation Plan] for people living at the service. This is an individual plan detailing how people will be alerted to danger and their safety maintained in an emergency. This could not be located, and it was unclear as to how long this had been missing. The management team took immediate steps to rectify this.

People's care and support needs were not provided in a safe way and risks to people were not always recorded. This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People's comments about staffing levels were variable. Positive comments included, "I can press the buzzer anytime I want. They [staff] come pretty quickly, no difference night or day, usually come pretty quickly", "There is always enough staff, weekends as well" and, "I buzz and they [staff] are here in a couple of minutes, never waited long."
• Where comments were less favourable these included, "If I need staff I usually find them in the lounge and when we [relative] are here they don't come and check on them" and, "Not enough staff, they [staff] have so much book work. You see staff sitting and writing all the time. [Name of family member] likes to have company and they [staff] don't have time to spend five minutes with them. The last couple of months it has gotten worse and they [staff] spend more time in the lounge." A second relative confirmed the latter's comments by stating, "I come at 1.15pm and they [staff] are still writing when I go at 2.00pm." Observations on both days of inspection confirmed what people told us. For example, on the first day of inspection on the nursing unit, three staff were observed to complete paperwork for between 30 to 45 minutes without interacting with five people sitting within the communal lounge. This was repeated during the inspection.
• Though the above was told to us, the deployment of staff on both days of inspection was appropriate and there were enough staff to meet people's needs. Staff were seen providing care and support to people promptly, with call alarm facilities answered in a timely manner.
• Staff recruitment records for four members of staff were viewed. Most relevant checks were completed before a new member of staff started working at the service. However, improvements were required as dates of employment were not always recorded and not all gaps in employment explored. One staff member's reference was received 10 days after they commenced in post. A robust written record was not completed to demonstrate the discussion had as part of the interview process and the rationale for staff's appointment.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe. One relative stated, "The staff are really lovely, when I go home I can go happy, leaving them [family member] with staff, they are safe here." One person using the service told us, "I am quite happy here, been here just over a year. I do feel safe, the fact you have a buzzer if you need it, even at night they [staff] pop in."
• Not all staff spoken with had a good understanding of what to do to make sure people were protected from harm or abuse. Where staff were able to demonstrate a good understanding, staff confirmed they would escalate concerns to a senior member of staff, the manager and external agencies, such as the Local Authority or Care Quality Commission.

Using medicines safely
• Suitable arrangements were in place to ensure the proper and safe use of medicines. The medication rounds were evenly spaced out throughout the day to ensure people did not receive their medication too close together or too late. Observation of staff practice showed staff undertook this task with dignity and respect for the people they supported.
• We looked at the Medication Administration Records [MAR] for 18 of the people. These showed most people had received their medication at the times they needed them, and records were kept in good order.

Preventing and controlling infection
At our last inspection to the service in September 2018, the registered provider had failed to ensure the premises were clean and hygienic. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found the majority of

improvements had been made and they were no longer in breach of regulation. However, further action was still required to make sure the premises was clean.

• The Local Authority completed their inspection of Bluebell Nursing and Residential Care Home in March 2019. The report recorded a bottle of bleach was easily available for people to access and there were three broken toilet seats and no top to one toilet cistern. At this inspection, the top of the toilet cistern had still not been replaced.
• A storage cupboard on the ground floor was unlocked during the morning. Several items were stored on a trolley which if swallowed or spilt on a person's skin could be potentially harmful and act as an irritant. This was immediately brought to the attention of the service's administrator and they told the cleaner to keep the cupboard locked. However, the same storage cupboard was left unlocked with the door open during the afternoon. This was brought to the newly appointed manager's attention.
• On the Memory Unit on the second floor, the drainage area within one shower facility was observed to emit an unknown odour and on further inspection was clogged with hair.
• Staff had received training in infection control and had access to personal protective equipment (PPE) such as gloves and aprons.

Learning lessons when things go wrong
• The newly appointed manager and consultant told us lessons would be learned and the required improvements made to achieve compliance with regulatory requirements.
• However, during and following the inspection, some members of staff told us they were wary about raising concerns with the registered provider and there was a culture of blame when things went wrong.
• The inspection highlighted that lessons learned, and improvements made were not always sustained.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• The training plan provided demonstrated most staff had attained mandatory training in line with the registered provider's expectations. Although our observations showed some staff were effectively able to apply their learning, others were not. This was because their training was not embedded in their everyday practice. The inspection reports highlights areas where some staff member's practice was poor, for example, in relation to manual handling, supporting people living with dementia and staff being able to effectively communicate with people using the service.
• Three member's of staff who commenced employment in March, May and the beginning of June 2019, were not included on the staff training plan. One member of staff confirmed the only training completed since their appointment related to fire awareness and manual handling. This was despite the staff member having no previous experience of working within a 'care' environment or with vulnerable people. No evidence was available to demonstrate the other two members of staff had completed mandatory training. The service's administrator confirmed there was no training file for either member of staff.
• One member of staff confirmed they were the service's 'dignity champion'. This is a specific role for staff that is aimed to promote best practice across the service, introduce new initiatives, share resources and cascade information to peers. However, the member of staff had not received additional 'dignity' training and did not have an understanding of the requirements of this role and the main areas of responsibility.
• Although staff told us they 'shadowed' experienced staff for three days as part of their induction and received mandatory training in their first week, not all staff felt their induction was robust. Comments included, "Would have liked longer as I was new to care" and, "The induction could have been a bit better."

• Staff supervision and support was not consistent. Supervision information for four members of staff demonstrated they had received regular formal supervision up to January 2019 but no supervisions after this date. A member of staff who commenced employment in March 2019 had yet to receive supervision. However, most staff spoken with told us they felt supported by the new manager.

Not all staff received appropriate training or supervision. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• The dining experience across the service was variable. The dining experience for people residing on the

residential and nursing units was generally positive. People had access to enough food and drink throughout the day and there were enough staff to provide assistance where people required specific support.
• However, the above was in contrast to people residing on the Memory Unit. Though people had access to food and drink, people were not always offered a choice of drinks or given the opportunity to make an informed choice relating to the meals available. Staff did not routinely provide a verbal description of the meal or food being offered, staff did not show people a plated meal relating to the choices available or provide pictorial images.
• One person became distressed at the start of the lunchtime meal on the Memory Unit. Though a staff member attempted to comfort the person, this had little effect. Instead of persisting with the support to lessen the person's distress, staff were instructed by the team leader to take the person to bed. The person was not consulted or given a choice to eat their meal at the same time as others using the service and received this later in the day.
• One person poured their drink onto their plate of food. A visitor to the service intervened and removed some of the fluid from their plate but not all. The relative informed a member of staff but this was not relayed to other staff members as a short while later a member of staff assisted the person to eat from the same plate. A new plate of food was not provided.
• There were missed opportunities for staff to engage with people using the service. Where staff assisted people to eat their lunchtime meal, staff did not routinely engage people in discussion, such as, asking people if they enjoyed their meal or provide words of encouragement where people were finding it difficult or were reluctant to eat. People were not consulted, and this resulted with plates of food being taken away and replaced by desserts.

• People's comments about the meals provided were positive. Comments included, "The food is very good, there are two choices and plenty of vegetables. The tea trolley has bananas and satsumas sometimes, there is always a jug of water and the last trolley is around 8.00pm" and, "There is always something I like [on the menu]. When my bottle is empty, they [staff] fill it up with blackcurrant and there is always lots of tea and coffee."

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• The service worked with other organisations to ensure they delivered joined-up care and support. This included the dementia support team, District Nurse services, local falls team and mental health teams for older people.
• People suggested to us their healthcare needs were met and they received appropriate support from staff. One person told us, "The healthcare is better here than when I was at home. The doctor comes here every week and if you want to see them, you tell the nurse. I see the chiropodist and my relative takes me to the dentist, optician and to hospital appointments." Another person told us, "I have got a bad foot and leg and they [staff] respect that I need care looking after me. The District Nurse comes every other day without fail."
• However, people were not supported to access regular oral healthcare checks and robust plans relating to people's oral health were not in place. It could not be determined from daily care records viewed what specific oral healthcare and support people received. In May 2019 the local Clinical Commissioning Group [CCG] provided an oral assessment tool and guidance to the service to progress. This had not been considered.
• The records for one person detailed poor oral health was impacting on their nutritional intake and accounted for a significant weight loss since January 2019. Though the person was awaiting a dental appointment, this had not been followed up by staff.
• We also found dry toothbrushes during our inspection which indicated they had not been used. We discussed our findings with the manager. They told us staff do undertake oral care for people using the

service and this should be recorded.

We recommend the registered provider seeks good practice guidance to ensure people's oral health care needs are met and familiarises themselves with the publication Smiling Matters 'Oral Health Care in Care Homes' published on 24 June 2019 by the Care Quality Commission.

Adapting service, design, decoration to meet people's needs
• Bluebell Nursing and Residential Home is a large purpose built care home within a residential area in Grays. The service is unitised on three floors, with the ground floor for people who require residential care, the first floor for people with complex nursing needs and the second floor for people living with dementia. People had access to two communal lounge areas and a separate dining area on each floor.
• People had personalised rooms which supported their individual needs and preferences.
• The environment lacked appropriate signage for people living with dementia and did not comply with the Accessible Information Standard. The use of orientation boards or information for people in an easy to understand format was not considered and improvements were required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to their admission and included their physical, mental health and social needs.
• People's protected characteristics under the Equalities Act 2010, such as age, disability, religion and ethnicity were identified as part of their needs assessment. Staff knew about people's individual characteristics.

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.

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 whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People's ability to make a specific decision had been assessed and best interest assessments completed but these were generic and not as person-centred as they should be.
• Staff received training relating to MCA and DoLS but were unable to demonstrate a good understanding of the main principles and how this impacted on people using the service.
• As detailed within this report, people were not always offered choice or consented to care.

Requires Improvement

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 has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People's and relatives comments about the care they or their family member received was generally good. People using the service told us, "Whenever you want help or to know something, staff respond and care for you", "They [staff] always knock on the door, say can I do 'so and so', they are very good on this floor" and, "They [staff] are not rude to me, anything I ask for they do it, they are alright, can be cheeky in a jokey way." Two relatives told us, "The girls are very good, had no problems, one of us [relative] comes in everyday" and, "Generally speaking they [staff] do care, one or two of the staff are lovely and give [family member] a kiss."
• Where less favourable comments were made by people's relatives using the service, these primarily related to people's perception of there not always being enough staff available. For example, "I enjoy it here, staff are very good, though they are always short at night, not enough when people are not well" and, "They don't always come into change [relative], sometimes I come in and they are sweating and they have not taken the covers off them." Relatives also commented about staff sitting in communal lounge areas whilst undertaking record keeping and ignoring people who used the service.
• Several relatives acknowledged their family member received support from staff with their personal care needs. One relative told us, "[Relative] is clean and tidy, people look after them well." However, some of the comments made suggested staff did not routinely shave people and family member's had to do this. Comments included, "No one [staff] seems to do that, would be nice if this was done" and, "They have shaved him today, that is the first time it has been done in the morning, is that because you [inspection team] are here? Shaving him would help and they [staff] could talk to him?"
• The above positive comments contrasted with the care and support experienced by some people. Care primarily focused on tasks and routines of the day rather than staff providing person-centred care. There was an over reliance on the television and although this was on throughout the day, people using the service were predominately either asleep or disengaged with their surroundings and not watching the television. Staff did not sit and talk with people for a meaningful length of time and staff interactions did not always ensure people got the time they needed to respond before staff walked away.
• Staff did not consistently engage with people in a meaningful way or for any length of time. For example, one person on the Memory Unit experienced two separate occasions whereby they were ignored by staff for between 25 to 35 minutes, despite staff being present within the communal lounge.
• An incident occurred whereby one person experienced a fall and required staff assistance to get up from the floor. Five members of staff and a visiting healthcare professional were gathered round the person. Though staff were clearly wanting to provide support to the person, it was unclear who was taking the lead or in control of the situation. Whilst staff talked amongst themselves, this delayed the support provided.

Supporting people to express their views and be involved in making decisions about their care
• People had been given the opportunity to provide feedback about the service through the completion of an annual questionnaire, but this was completed prior to our previous inspection in September 2018. The registered provider confirmed the annual questionnaire for the period 2018 to 2019 would be completed in the next few months.
• People were aware the service had a written plan but did not know what was written about them. Although there was little evidence to show people were actively involved in this plan, some people stated their relatives were involved. One person told us, "The care plan is showed to my relative, I don't do that."
• People residing on the Residential and Nursing Units, told us they were able to choose what time they got up in the morning and the time they retired to bed. People also told us they were able to choose how and where they spent their day. One person told us when asked about choice and being able to make decisions, "Choice, yes I have choice. Staff get me up at 7.30am, I am happy to get up then. Usually I am in my room, but I can wander about where I want. I am independent and walk to the games room, it is nice and quiet in there. I don't take part in anything [social activities], my choice. There is a dining room down the corridor, but I prefer to eat here in my room."
• The above was in contrast to people living on the Memory Unit. We were not assured that staff always understood the importance of giving people choices or how to support people that could not always make decisions and choices for themselves. People were observed not always being offered choice in relation to drinks. Not all people were able to communicate their specific wishes and preferences relating to the meal choices available. The menu was not displayed in an appropriate format and people were not physically shown the meal choices available to enable them to make an informed choice.

Respecting and promoting people's privacy, dignity and independence
• As cited within this report, not all people were treated with respect. For example, most staff interactions were with one another rather than with people using the service.
• People's independence was promoted, and staff encouraged people to do as much as they could for themselves. One person told us, "They [staff] enable me to stay independent. I wash and dress myself and walk to the dining room."
● People's privacy and dignity was respected. Staff could tell us how they protected people's dignity, for example when providing personal care, by ensuring doors and curtains were closed.

Requires Improvement

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 has now deteriorated to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; end of life care and support

• As highlighted in the 'safe' and 'effective' section of this report, people's care records did not fully reflect or accurately detail people's care and support needs or provide sufficient guidance for staff as to how people's needs were to be met. For example, one person's care plan [May 2019] suggested their skin integrity had been compromised but was now healed. However, this was not correct as their care plan evaluation dated June 2019, confirmed their skin integrity remained compromised. The person's care plan had not been updated. Dietary advice provided by a healthcare professional was not included within another person's care plan.

• Some of the information recorded was generic and not person-centred, for example, information recorded relating to people's capacity to make day-to-day decisions was generic.

• Though there was no evidence to suggest people were not receiving appropriate care, no information was recorded relating to pain management arrangements and how the person's end of life care symptoms was to be managed to maintain the person's quality of life as much as possible. Not all staff supporting people on the Nursing Unit had received end of life care training. Not all staff working on the Nursing Unit were able to tell us who was assessed as requiring end of life care.

• The service worked collaboratively with other services and professionals, such as, local hospices and palliative support teams.

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

• There were two staff members responsible for facilitating social activities at the service for 18 hours each week. The third facilitator had left in September 2018 and had not been replaced by the registered provider.

• People received limited opportunities to participate in meaningful social activities. On day one of the inspection, the service was without a social activities facilitator. There was an over reliance on the television and although this was on throughout the day, people using the service were predominately either asleep or disengaged with their surroundings and not watching the television. As highlighted within other sections of this report, staff did not consistently engage with people in a meaningful way or for any length of time.

• Records confirmed our observations. For example, information available for three people on the Memory Unit recorded for the period January to June 2019, they had participated in three to nine activities. This was similar for people residing on the Residential and Nursing Units. The activities facilitator told us the lack of a third member of staff impacted on the activities being offered and provided to people using the service. In

particular, one-to-one time was compromised for people living on the Nursing Unit.
• On the second day of inspection the activities facilitator was available. They initiated a game of bingo with 11 people on the ground floor and darts on the Memory Unit. They also supported one person with a puzzle and others were given a book to look at.

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

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.
• The service was not doing all they could to ensure staff were able to effectively communicate with people using the service. For example, aids to support effective communication were not considered for two people on the Memory Unit and whose first language was not English. The service had not considered the services of an interpreter or other communication aids to translate keywords or key phrases into an alternative language. This presented a risk of people feeling socially isolated, not being able to express their needs and preferences to enable meaningful dialogue.
• As highlighted in the 'caring' section of this report, the menu and activity programme was not displayed in an appropriate format for people living with dementia or who had a sensory impairment, such as, easy read or large print formats.

We recommend the registered provider research good practice guidance on meeting people's communication needs.

Improving care quality in response to complaints or concerns
• The service's complaints procedure was displayed, and this provided people with necessary information needed to raise a concern or complaint.
• Arrangements were in place to record, investigate and respond to any complaints raised with the service. No complaints had been received since our last inspection in August 2018.
• People told us they knew how to raise a complaint and felt they would be listened to, and their concerns acted upon. One person told us, "To complain I would tell the nurse in charge, there is one on all the time." Another person told us, "I would go to [staff member's name], they are in charge down here, they are very good."
• A record of compliments was maintained detailing the service's achievements.

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 now remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• Effective governance and quality monitoring arrangements were not in place. This was because not all risks for people using the service were identified and staff's practice did not ensure people's safety and wellbeing. Staff practices were not monitored to ensure people were always treated with the utmost respect, ensuring care provided was 'person-led' rather than 'service-led' and that staff effectively communicated with the people they supported. Improvements were required to record keeping and examples of inconsistent record keeping are cited within this report. Suitable arrangements were not in place to make sure staff had the skills and knowledge to deliver effective care and support. These areas were not picked up by the registered provider's quality assurance arrangements. There was a lack of understanding of the risks and issues and the impact on people using the service.

• There was a lack of oversight by the registered provider and their representative's, based on observations of actual care being provided by staff and being experienced by people living at the service. Though there were many audits and checks in place which were completed at regular intervals, these checks had failed to identify and address the concerns found as part of this inspection or to help drive improvement and lessons learned.

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

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

• The ratings and report from our previous inspection were displayed at Bluebell Nursing and Residential Care Home and on the registered provider's website.

● Throughout our inspection, the manager and consultant were receptive to our findings and suggestions, and demonstrated a commitment to improving the service to enable greater oversight and governance of the service, making sure people received safe care and treatment.

• Prior to our inspection the registered manager had resigned, and a new manager appointed from within the organisation. The consultant confirmed the newly appointed manager would receive an induction to

their new role in due course.
• Improvements were required to ensure where staff were given a designated role, for example, as a 'champion' of a specific topic, they received appropriate training and understood what was required of them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's views of the service. No questionnaires had been completed since our last inspection. The registered provider informed us these were undertaken annually and were due to be completed within the next few months.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service.

Working in partnership with others
• Information available showed the service worked in partnership with key organisations to support care provision and joined-up care.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans did not fully reflect or accurately detail people's care and support needs. People received limited opportunity to participate in social activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and support needs were not provided in a safe way and risks to people were not always recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance and quality monitoring arrangements were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff received appropriate training or formal supervision at regular intervals.