Bluewater Care Homes Limited

Bluewater Nursing Home

Inspection report

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Portsmouth
Hampshire
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bluewater Nursing Home is a residential care home providing personal care to 29 people aged 65 and over at the time of the inspection, an additional person was in hospital. Some people were living with dementia. The service can support up to 60 people. Although it is called a 'nursing home', it does not provide nursing care.

The home is based on three floors with an interconnecting passenger lift, although only the lower two floors were in use at the time of the inspection. The home is in the heart of Portsmouth, on a main street with lots of local shops.

People's experience of using this service and what we found
Medicines management was not always carried out safely, improvement was required with medicines records.

Care plans and risk assessments did not always contain enough detail to inform staff about people's needs and in some instances risk assessments were not in place where needed. There was a lack of guidance to staff in relation to nutrition and hydration. People receiving care were at increased risk of choking.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

It is a requirement of registration that all significant events are reported to CQC. CQC was not always notified about significant events that occurred at Bluewater Nursing Home.

Quality assurance systems had not always been effective in identifying the concerns we found at this inspection and bringing about improvement.

Infection control practices were not always carried out safely. A child visiting the service was not social distancing and did not wear a mask. We have made a recommendation about this.

Safe recruitment practices were not always followed. We made a recommendation about this.

Staff were positive about the management of the service and told us the registered manager was very supportive and approachable.

Staff told us they were supported by regular training and supervision. People were supported to access other healthcare services in a timely way. Many adaptations had been made to the home to meet the needs of the people living there.

The registered manager demonstrated a willingness to make improvements and during the inspection began reviewing their systems and processes to ensure the service consistently provided good, safe, quality care and support.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 October 2018), there was one breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

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 provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, nutrition and hydration and non-notification to CQC of incidents. A decision was made for us to inspect and examine those risks. We also undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Safe, Effective and Well-led Key Questions which contain those requirements and concerns which had been raised.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bluewater nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe management of medicines, safe management of food and nutrition, consent, good governance and failure to notify, at this inspection.

Follow up
We identified four breaches of regulation and because this is the third consecutive time the service has been rated as requires improvement we will request a clear action plan from the provider to understand what they will do to improve the standards of quality and safety. We will also meet with the provider following receipt of this plan. We will work alongside the provider and 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bluewater Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was conducted by two inspectors.

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

Notice of inspection
We gave a very short period notice of the inspection because of the Covid-19 pandemic. Inspection activity started on 12 November 2020 and ended on 10 December 2020. We visited Bluewater Nursing Home on 12 and 24 November 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from a professional who works with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with six people who used the service and six relatives about their experience of the care provided. We spoke with nine members of staff including the director, registered manager, head of care, care workers and the cook. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People's care plans and risk assessments did not always contain the information needed to keep people safe. Where people had specific health conditions, there was not always an associated care plan or risk assessment. For example, one person who had chronic, obstructive, pulmonary disease (COPD) did not have a care plan or risk assessment in place guiding staff how to support them. Another person's care plan referred to their medical conditions using acronyms. For example, CKD instead of Chronic Kidney Disease and HTN instead of Hypertension. When we asked staff what the initials stood for, they could not tell us. There were no care plans or risk assessments to guide staff how to support the person who had these conditions. We spoke to the head of care about this and she was unable to tell us what the acronyms meant. This meant people were at risk of not having their healthcare needs met. Following the inspection, the provider sent us a care plan and risk assessment which had been updated to contain details about these conditions.

● One person was at risk of choking and a speech and language therapist (SaLT) had recommended they required a specific diet. However, we saw from records that this was not always followed. This put the person at a high risk of choking. For example, notes for one person who was on a soft diet showed they had been given cereal and toast.

● Guidance on how to manage risks to people from choking was not always available, accurate or followed by staff. We found examples that included; lack of detail about the consistency and type of food people could eat or should avoid. A care plan review had failed to identify a food which posed a risk of choking. It was no longer eaten by the person and should have been removed. Records of food and fluids given did not provide enough detail to show people received food and fluids at a safe or recommended consistency for them. Guidelines from the SaLT team were not always followed or available for staff to follow.

● The cook provided puree food to six people who were identified as needing any kind of adapted diet. This meant people's choice was being restricted and they were not being provided with a variety of foods that they could manage. The cook did not have a good understanding of the food requirements for people who lived with a diagnosis of diabetes. We spoke with the provider about this who told us this was the cooks second day of working unsupervised. Following the inspection, the provider sent us pictures of the board in the kitchen which had been updated to identify individuals' specific diets. The provider told us the cook no longer worked at the service.

● On day one of the inspection we identified two bedrooms fire doors were being held open with objects. The registered manager was responsive to this and removed the objects holding doors open, they also reiterated to staff the importance of not wedging open fire doors. On day two of the inspection we did not see any fire doors being held open.

● Risk assessments were in place regarding falls however, they did not always contain guidance to staff on

what to do should the person fall. However, staff we spoke with knew what to do in these situations and described reporting immediately to a senior and contacting emergency services if required.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate risks were effectively managed. The failure to effectively assess, monitor and mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was responsive during the inspection and demonstrated a willingness to improve.

Using medicines safely

● Medicines were not always managed safely. For example, we observed one person's prescribed cream was left unsecured and creams were not always labelled with people's name. This meant there was a risk that people could access creams not meant for them and a risk that people could ingest the creams. Opening dates were not always recorded. This meant that people were at risk of being administered creams which were no longer in date, once the expiration date has passed there is no guarantee that the medicine will be safe and effective.

● Two people had been prescribed a skin care product which is used to treat and prevent dry and itchy skin conditions. Both people had run out of this product and there was none in stock. This meant they did not have access to the required treatment for their conditions.

● The provider used an electronic medicine system. We identified some discrepancies between the number of tablets recorded as in stock on the Medication Administration Records (MAR) and the number of tablets counted. The provider's internal medicine audit failed to identify this shortfall.

● The head of care investigated this and informed us of their findings. They concluded people had received their medicines and this was a recording error. They told us they would increase the auditing of medicines.

● PRN protocols guide staff when and how to administer 'as required' medicines. We identified eight PRN protocols were not in place for people. This meant staff did not have enough guidance and people were at risk of not receiving their required medicines or not receiving the correct dose.

● Following the inspection, the provider sent us two paper PRN protocols predating the inspection however, the head of care did not know where these records were, therefore they were not available to staff.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe medicines management was effectively managed. The failure to ensure safe management of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed the concerns we found with medicines management had been rectified.

● Staff had received training in the administration of medicines and had been competency assessed.

● There was a robust system for the safe ordering and disposal of medicines.

● Risk assessments were in place for people who were prescribed flammable emollient creams. This meant the increased risk of fire associated with these creams was reduced.

Systems and processes to safeguard people from the risk of abuse

● Although systems were in place to safeguard people from abuse, these had not always been followed. For example, Although the registered manager investigated safeguarding concerns and reported them to the local authority, they did not always report allegations of abuse to CQC as required. You can read more about

this in the well–led section of the report. This meant CQC were not always made aware of these incidents so were unable to monitor the safety of the service or offer support to develop protection plans.
● Despite this, staff had received safeguarding training and had an adequate knowledge about how to recognise signs of abuse and keep people safe from harm. They told us they would report any concerns to the registered manager whom they felt would act appropriately to ensure people were safe.
● The registered manager told us they would update CQC with any future safeguarding concerns.
● Relatives felt people were safe living at Bluewater Nursing Home. For example, one relative told us, "They keep a check on her, feed her, make sure she's clean, they talk to her, they have been very, very good with mum, I am very pleased." Another relative said, "The staff are particularly good, very kind, caring and very dedicated to their job. I haven't seen policies and procedures, I just know that [person] is safe."
● People told us they felt safe, their comments included, "They [staff] are always there, always people going around at night, making sure you're ok" and, "Yes, I feel safe."

Staffing and recruitment
● People and their relatives had mixed views about staffing levels in the home. Two people told us staffing levels were adequate, another two told us it depended on the day. Two relatives told us staffing levels were ok, one told us staff were far too busy and three relatives had not been able to go to the service due to COVID-19.
● Most staff told us the staffing levels were enough, although it was busy. One told us most of the time there were enough staff however, staff sickness impacted on this.
● During the inspection, we found call bells were answered promptly and staff did not appear rushed.
● We discussed staffing levels with the registered manager who showed us they used a dependency tool to determine how many staff were needed according to the number and dependencies of people in the home.
● Safe recruitment practices were not always followed. For example, gaps in the employment history of staff were not always followed up to ensure there was a satisfactory written explanation for this. This meant the provider was not always able to consider whether the applicant's background impacted on their suitability to work with people.

We recommend the provider seeks reputable guidance on the safe recruitment and employment of staff and updates their practice accordingly.

● The provider told us they had never used agency staff. They told us their staff team and the management pick up additional shifts when the need arises.

Preventing and controlling infection
● People and staff were not always adequately protected from the risk and spread of infections, including COVID-19. During both days we were on site, a child was in the care home. The child was interacting with people without socially distancing and was not wearing a mask. Following the inspection, we received a concern about this. This meant despite the robust practices that were in place for visitors' people were placed at risk of contracting COVID-19 from the child who mixes with other children in their school environment. We spoke with the registered manager and the provider about this. The provider told us the child does normally wear a face mask and would always wear one going forward. The local authority has been informed who will investigate this and ensure the service is carrying out safe practices.

We recommend that the provider researches current guidance and updates their visitor's policy and infection control procedures to include any children that may be visiting the care home.

● Some robust processes were in place. On arrival we were asked to wear an apron and mask, our

temperature was taken, and we were requested to complete a form which asked questions about our recent contact with people. It also provided the service with contact details for track and trace.

● The laundry room was clean and organised. There was an effective system to reduce the risk of cross contamination between dirty linen and clean linen.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

Learning lessons when things go wrong

● The registered manager had a system to record accidents and incidents and an analysis of accidents and incidents had taken place, themes and patterns had been identified and preventative measures put in place.

● Risk assessments and care plans were reviewed following incidents.

● The registered manager described an incident that had occurred. They told us they had updated the policies and procedures in relation to the incident and documents confirmed this. The registered manager told us, "We communicated to all residents and their family and explained what we did about it."

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.

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.

- The principles of the mental capacity act were not always followed. One person's care plan stated they could have hard sweets which was in contradiction to their SaLT guidelines, there was no evidence that a mental capacity assessment was carried out or a best interest meeting held. We spoke with the Head of care about this who told us, "We have not got one." The Head of Care said they would complete mental capacity assessments and best interest meetings where required.
- The same person's care plan stated they had a representative to manage their finances. The provider was unable to evidence the representative had a Court of Protection order to legally enable them to manage this person's finances. The order is a legal document from the Court of Protection that appoints someone to make decisions on an account holder's behalf due to their loss of mental capacity. There was no evidence that a mental capacity assessment or best interest meeting had taken place in relation to this person's finances. The head of care confirmed they did not have one.
- We found an assessment for one person was not robust as it covered a wide range of decisions. The MCA applies to situations where someone is unable to make a specific decision at a particular time because of the way their mind or brain is affected.
- For some people the principles of the MCA had been followed and best interest meetings had taken place where relevant. DoLS authorisations had been applied for where people required them.

● The registered manager and staff spoke confidently about the principles of the MCA.

The failure to provide care and treatment of service users with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care was not always planned and delivered in line with people's individual assessments and these were not always updated when circumstances changed. For example, care had not been delivered in line with SaLT guidance. This meant people were at risk of receiving foods which put them at risk.
● People's needs were assessed before they moved into the home. Once this information was gathered, it was used to develop people's support plans and risk assessments with the support of people and their relatives.
●Staff completed regular assessments of people's ongoing needs using recognised tools for areas such as nutrition and skin integrity.
● People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessment process. Care plans detailed people's diverse needs in relation to religion, culture and disability including their preferences for the gender of the staff supporting them.
● Staff had received training in equality and diversity and policies were in place to support meeting people's equality and diversity needs.
● The service has a small church area which people who chose to could access. The registered manager told us, "During lockdown we have still been able to access the church for people, we have a virtual link to [a church] via zoom every week."

Staff support: induction, training, skills and experience
● Staff received regular supervisions in line with their policy. Staff told us they felt supported by the management team and felt able to gain support from them at any time.
● Staff received a variety of training including, MCA and DoLS, fire safety and safeguarding. Staff had received training specific to people's needs. For example, dementia training and end of life care. In addition, staff had access to over 40 different training sessions electronically.
● Staff had completed a comprehensive induction which included the completion of the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff working in the care sector. People and their relatives told us staff were skilled and experienced. One person told us, "They are well trained in lots of things, some are higher than the others. They know what they are doing." Relatives comments included, "I think they do an amazing job yes, they are all very friendly" and, "They do a good job they are brilliant, overworked, stressed on occasions, hearts of gold, very good to mum, she tells me, she is very articulate. Staff are great."

Supporting people to eat and drink enough to maintain a balanced diet
● Most people were provided with a nutritious and balanced diet and a choice of meals and drink. However, people on a soft diet did not have a choice and were provided with food in a puree texture. This meant they were not being offered a range of textures suitable for their diet. One family member told us their relative was not always offered a choice and that a meal was often chosen for them.
● A range of drinks were available for people to help themselves to from a hydration station throughout the day. One person told us, "I always have a jug in my room. When we are down in the lounge, there is more coffee, tea and soft drinks. After lunch, I'll stay downstairs, in the hot weather they were constantly getting me to drink."
● People were positive about the food on offer. One person told us, "You have good meals every day. You get two choices, if it's that you don't like either, they do something else for you." A relative said, "Whenever I

speak to mum, she always says the food is good, so she seems happy with it." Another relative said food had not always been good, they told us, "They have had a stream of cooks, three or four whilst [person name] has been there. There is no consistency. Last time I spoke to her she said the food had improved."

● We observed the lunchtime experience and found that people enjoyed their meals and were supported in a positive and appropriate way. People were offered a choice of where to eat.

● The cook was not aware of peoples SaLT guidelines, and risks to people from choking were not always managed safely you can read more about this in the safe section of this report.

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

● The home was warm and welcoming, and people were able to personalise their rooms as they wished. We saw rooms were individual to people's tastes and contained items personal to them.

● The home had been adapted to meet the needs of people, there was a lift which connected the three floors of the home. Doors and corridors were wide to accommodate hoists and wheelchairs. Signs on doors made them easier to find. There were large directional signs outside the lift area however, due to the large size of the home it would benefit from additional directional signage to further support people to find their way around. We spoke to the registered manager about this who told us they would put additional directional signs up.

● There were several areas of interest for people to access which included a replica railway carriage with authentic features, the windows of the train carriage were replaced with screens to simulate travelling through a variety of landscapes. There was an ice-cream and waffle parlour which included the original dance floor from the building's previous life as a nightclub, as well as a cinema. The latest addition was an aeroplane cabin with genuine seats and overhead luggage bins and original plastic pull down windows. The provider told us, "We find this area can really help ignite memories and the residents enjoy sitting in the plane talking and laughing."

● The provider had recently purchased a sensory table which can be transported to people's rooms and positioned to enable them to use it. The sensory table includes over 2000 different games and activities which can be set at different levels of difficulty.

● There was a pub built in the dining room, the provider told us this was to accommodate those who wished to use it and to encourage socialising.

● There was a hairdressing and beauty parlour. Following the inspection, the provider told us in writing, 'residents have all sorts of pampering treats completely free of charge.'

● Bedroom doors were personalised with memorabilia of the persons choice, this included photographs, names and posters, each door had a door knocker and room number. The provider had sought advice from Sterling University when considering colours to paint doors to ensure it was dementia friendly. The provider told us they had 14 dementia champions within the home. They told us in writing, 'This gives the majority of our employees a really deep sound insight into the residents wants and needs.'

● Following the inspection, the provider sent us pictures of their transport hub which included a black cab, bus stops and maps and was available for people to use to stimulate people's imagination.

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

● People were supported to access services to maintain and improve their health. A relative told us, "She gets support she needs."

● Any changes in people's health were recognised promptly and support was sought by external healthcare workers when necessary, this was documented in peoples notes.

● The registered manager promoted the importance of close working relationships with external agencies, for example, the local authority safeguarding team, the diabetes nurse and the GP.

● Staff told us they worked well as a team and took part in daily handovers and communicated well with

each other to ensure good outcomes for people.

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 Requires Improvement. At this inspection it has 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.

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

At our last inspection a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. This was because the governance of the service was not effective. At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 17.

● Quality assurance processes were in place and consisted of a variety of audits however, these had not been effective at identifying the concerns we found during the inspection. For example, we identified SaLT guidelines were not clear or available and food was not always provided in the correct safe texture, records in relation to medicines management were not always accurate and creams were not always labelled, risk assessments did not always identify the action staff need to take should the risk occur, and some care plans lacked the detail they required to ensure people were supported safely and staff had the correct information..

The failure to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity and the failure to maintain securely an accurate, complete and contemporaneous record in respect of each person was a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014.

● The registered manager was responsive to our feedback and either acted promptly to make improvements or told us of their plans about some of the changes they were going to put in place following the inspection.
● The registered manager demonstrated commitment to the service and was working hard to make improvements at Bluewater Nursing Home. However, this was the third consecutive rating of requires improvement.
● There was a clear management structure in place and staff knew who to contact when they required support. The registered manager was supported by the provider and staff were supported to understand their roles and responsibilities through regular team meetings and supervision.
● Providers are required to display their CQC rating at their premises and on their website if they have one and we saw this was prominently displayed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred.
● There were processes in place to help ensure, if people came to harm, relevant people would be informed in line with the duty of candour requirements. However, CQC were not always notified of all significant events. We identified four significant events from August, September and October 2020 which had not been notified to CQC. We spoke to the registered manager about this who immediately arranged for these to be sent to CQC. The registered manager told us they would update their monitoring system to ensure all future notification were sent to CQC when required. The provider had contacted all the other relevant people including safeguarding and family members.

The failure to notify CQC of significant events was a breach of Regulation 18 under the Care Quality Commission (Registration) Regulations 2009 (Part 4).

● Following the inspection all four notifications were received and had been dealt with in the appropriate manner and the registered manager had updated their audit tool to have better oversight of this.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● All people we spoke to and most relatives told us they were happy with the management of the service and they would be happy to recommend it to others. One person told us, "We have a monthly paper, the Bluewater something, it tells you all about what's going on. It's a good place."
● The provider and the registered manager were passionate about their values and were clear about the standard they expected everyone to work to.
● Staff talked about the values of the service and had a good understanding of what was expected of them, this was covered in team meeting and supervisions.
● People were supported to be as independent as possible, one person was given a staff tunic and helped with the tea trolley. This was something she valued and was made to feel like part of the staff team.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People and their families were asked for feedback on a regular basis which enable them to express their views. One person told us, "The staff are very good. If you have got a grievance, you only have to tell them, and they sort it out." Most relatives were positive, their comments included, "They [management team] are always easy to talk to and they do respond appropriately. They set up WhatsApp straight away when we request it", "It is friendly and if you ever have a problem you can always speak to them and they deal with it", "If I am worried, they tell me everything I want to know I ring [registered manager] and she rings me. She tells me what's wrong and she told me all about an incident which occurred" and, "The staff make it a really good standard care home, I don't think that necessarily comes from the top."
● The provider told us relatives and residents kept in contact via various online platforms and approximately 30 to 40 calls are carried out weekly. They told us in writing, 'We know this is an uplifting experience for the residents and relatives.'
● All staff we spoke to told us they felt supported in their role and the director and registered manager were always available to offer support.
● Staff were supported with regular supervision and team meetings.
● The service worked in partnership with other professionals to ensure people received effective, joined up care. Documents demonstrated people had access to a wide range of professionals when required or requested.
● Links had been established with local groups, for example, local primary schools who prior to COVID-19

would come into the home at Christmas to sing carols.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure to notify CQC of significant events was a breach of Regulation 18 under the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to provide care and treatment of service users with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate risks were effectively managed. The failure to effectively assess, monitor and mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems were either not in place or robust enough to demonstrate safe medicines management was effectively managed. The failure to ensure risks were assessed and effective plans implemented to mitigate these and a failure to ensure safe management of medicines was a breach of regulation 12 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to maintain accurate, complete and contemporaneous records in relation to each person using the service, including a record of the care and treatment provided was a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014.