Bluewater Care Homes Limited

Bluewater Nursing Home

Inspection report

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Ratings

Overall rating for this service

Overall summary

We carried out an unannounced inspection of this service on 25 February 2015 following concerns which had been raised by members of the public. Bluewater Nursing Home is registered to provide accommodation and nursing care for up to 60 older people. The home is a large, converted property and accommodation is arranged over four floors, the ground floor offering dining, recreational and reception facilities, with an additional three floors of accommodation which also contained some smaller recreational areas. Two lifts are in place to assist people to move between the four floors. All rooms are for single occupancy and have en suite facilities. There were 13 people living on the first floor of the home at the time of our inspection.

The service was inspected but not rated at our visit as it was newly registered with CQC in September 2014 and accommodated the first people for residence in November 2014. We do not have enough evidence to rate the service.

Immediately following the registration of the service with CQC the registered manager left the service. At the time of our inspection, a registered manager had not been in post since September 2014. However, a new manager had been appointed in December 2014 and had submitted an application to CQC to become registered. A registered manager is a person who has registered with the care Quality Commission to manage the service. Like

Summary of findings

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.

People felt safe at the home. Relatives had no concerns about the safety of people. However, risk assessments had not always been completed to ensure people received safe and effective care in line with their health conditions such as epilepsy or breathing difficulties. Care plans, whilst individualised to include people's preferences, often lacked clarity and clear guidance for staff on how to meet the needs of people with a health condition.

Staff at the home had not been guided by the principles of the Mental Capacity Act 2005 (MCA) when working with people who lacked the capacity to make decisions. Staff lacked knowledge and understanding of the MCA The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Two people who lived at the home were subject to a DoLS. Whilst all appropriate actions had been taken to support these people, care records did not reflect the impact these DoLS had on the people and actions staff should take to ensure their safety.

People were protected by staff that had a good understanding of the risk of abuse against vulnerable people. Staff were confident to report any concerns they may have through the appropriate channels. However, not all staff had received appropriate training in this area.

There was sufficient staff available to meet the needs of people. Through recruitment and training processes, people were cared for by people who had the right skills to meet their needs.

People were supported by competent staff to take their medicines safely. People had access to health and social care professionals as they were required.

People found staff to be caring and supportive. Staff knew people at the home well; they addressed people in a calm and dignified way and understood their needs.

Staff encouraged people to participate in activities, and offered them choice when they did not want to participate in any planned events. People were happy in the home.

People were provided with opportunities to express their views on the service through meetings and in discussion with the providers and manager. Meetings were being planned to implement a new format of care records with people and their relatives/representatives to allow them to express their views.

A programme of audits was completed by the manager to ensure the welfare and safety of people. These audits and reviews had identified concerns with care records and a lack of information around the capacity of people to consent to their care and treatment. These areas were being addressed.

People who worked and lived at the home felt able to express any concerns they may have and have these responded to promptly. The manager and provider promoted an open and honest culture of communication in the home and people responded well to this. Processes were in place to address and learn from any complaints, incidents and accidents.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Risk assessments had not been completed to ensure people who had specific health conditions had their needs met.

The manager and staff had a good understanding of the systems in place to report concerns of abuse, however not all staff had received training. The manager had worked closely with the local authority to address concerns raised.

There was sufficient staff to meet the needs of people. Recruitment and training processes were in place to ensure people with the right skills were employed in the home, although these had not all been completed.

Medicines were stored and administered safely by staff that had received appropriate training and had been assessed as competent.<Findings here>

Is the service effective?
The service was not always effective.

Where people lacked capacity to make decisions about the care they received, the registered manager and care staff had not applied the principles of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were skilled in the meeting of people's needs, however not all staff had received the training they required to support their role. The provider was addressing this.

People were provided with a choice of nutritious food and drink.

People had access to health and social care professionals to make sure they received effective care and treatment.

Is the service caring?
The service was caring.

People found staff to be very caring and supportive, and they gave people opportunities to express their views on the service.

Staff knew people well and were respectful of people.

Is the service responsive?
The service was not always responsive.

People felt able to raise any concerns they may have about the service and were sure they would be dealt with promptly. The home's complaints policy was visible for people to use.

Care records were individualised, however they lacked clarity and clear information to guide staff. The manager was aware of this and was taking action to address this.

There were a range of activities for people to enjoy at the home.

Is the service well-led?
The service was not always well led.

Summary of findings

The provider did not have an effective system in place to monitor and assess the number of staff required to meet the needs of people as the service size increased.

A programme of audit and review had identified areas of concerns with care records which were being addressed.

The manager and provider were approachable and provided an open, honest and effective work ethos at the home. People felt included in the running of the home.

Bluewater Nursing Home

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.

The inspection took place on 25 February 2015 and was unannounced. One inspector and an expert by experience in the care of older people visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We had received information of concern about this service from members of the public. Before our inspection we reviewed the information we held about the home, including the application they had made to CQC to register as a nursing home in September 2014. We reviewed notifications of incidents the provider had sent to us their initial registration. A notification is information about important events which the service is required to send us by law.

We spoke with nine people who lived at the home and two relatives who were visiting, to gain their views of the home. We observed care and support being delivered by staff in communal areas of the home. We spoke with the new manager of the service and the registered providers. We spoke with four members of staff.

We looked at the care plans and associated records for five people. We looked at a range of records relating to the management of the service including; records of complaints, accidents and incidents, quality assurance documents, four staff recruitment files and policies and procedures.

Following our visit we requested information from two health and social care professionals who supported some of the people who lived at Bluewater Nursing Home, to obtain their views of the home. We received feedback from one of these people.

This was the first inspection of the service since the home registered with the Commission in September 2014. The service was inspected but not rated.

Is the service safe?

Our findings

People felt safe at the home; however they did not always feel there was enough staff on duty to meet their needs. One person said, "There has been a lot of entries [people to the home] and the people-to-staff levels are at saturation point." Another said, "Today there are not many staff." Relatives spoke highly of staff and felt assured their loved ones were safe.

Risk assessments were in place for some people to provide guidance for staff to keep people safe; however, these were not always completed. For people who had specific health care needs, care records did not always adequately identify the risks and reflect the support people might require to manage these health conditions. For example, one person lived with epilepsy; however, their care records did not reflect any information on the risks associated with this condition or how staff should support them in the event of a seizure. Another person had a long term breathing condition; their care records held no information to guide staff on how to identify and minimise the risks associated with this. We asked the manager how they would identify the risks associated with specific health conditions and understand how these could be minimised. They told us they were planning to organise training for all staff to meet these needs. People were at risk of not receiving the care they required to support them with specific health needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a personal emergency evacuation plan in place (PEEP) which was kept at the reception desk for use by emergency services. These plans were not held in people's rooms or care records and staff did not have access to this information to ensure they were aware of any plans of care for people in the event of an emergency. Staff were aware the home had an efficient fire safety system which meant people should remain in their rooms in the event of fire. Staff training records showed five of 11 staff had not received fire safety training; however staff understood the procedures to be followed in the event of an emergency.

We had received information that staffing levels to meet the nursing needs of people were insufficient. There was sufficient care staff to meet the care needs of people on the day we inspected, however there were no registered nurses employed to provide nursing care for people. The provider told us, since they had been registered with CQC; they had not allowed any people to be admitted to the home with nursing needs as they were not yet ready to provide nursing care in the home. There were no people who required continuous nursing care at the home. Staff had sought appropriate support from the community teams if they required nursing advice.

If people wanted to participate in activities away from the area of the home in which they received their care, there were not sufficient care staff to meet this need. The provider and manager told us, due to the current number of people in the service, all staff worked together to assist people to move to other areas of the home if they wished to do this. This included the manager, the provider and any administrative staff. Records showed staffing levels had remained consistent at the home since it opened. The provider told us they had a recruitment program in place to ensure they were able to meet the increasing numbers of people who were going to be admitted to the home; however they had no formal process in place to identify how the needs of people would be met as the number of people at the home increased. The provider told us they did not plan to admit people with 'nursing needs' until they had recruited sufficient registered nurses.

Recruitment records for staff included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

The manager had a good understanding of what actions to take when any issues of a safeguarding nature were brought to their attention. They had worked closely with the local authority team to address two safeguarding concerns which had been raised with the local authority in the previous two months. Staff had a good understanding of the types of abuse which they may observe and how to report this; however records showed only six of eleven staff had received training in safeguarding of people.

People received their medicines in a safe and effective way. Staff ensured the medicines trolley was secure at all times and never left unattended when in use. There were no gaps

Is the service safe?

in the recording of medicines being given on medicine administration records (MAR) and people were supported to take their medicines in a calm and respectful way. Medicines given as required (PRN medicines) were charted and staff monitored and recorded the effectiveness of these medicines in people's care records. The manager told us a senior member of staff would be taking responsibility for the audit of medicines. Medicines were stored in accordance with legislation and all staff who administered medicines had received appropriate training and updates.

Is the service effective?

Our findings

Staff knew people well and people were happy with the care they received. Relatives were happy with the way in which their loved ones were supported. One relative was 'extremely happy" with the way their loved one had been supported to settle in their new environment and made to feel welcome. "They let [person] take their time and find out what [person] needed so they felt involved in each decision they made." People said staff were kind and always helped them. One person said, "I know what I want, and they always help me to do it."

Where people had capacity to consent to their treatment, we observed staff sought their consent before care or treatment was offered. Consent forms were not consistently completed in people's records although some people had consented to the sharing of their information and photographs.

People who lacked capacity to make decisions about their care and safety had not been always been assessed and supported to ensure their needs were met in line with their wishes or best interests. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interests decision should be made involving people who know the person well and other professionals, where relevant. The manager had identified this work was required and we saw they had started to complete mental capacity assessments where required.

For two people, Deprivation of Liberty Safeguards (DoLS) had been applied for with the local authority. Whilst the application forms for these DoLS had been included in people's care records, there was no supporting information for staff on how the person's needs should be met in line with these.

We had received information to suggest people were not able to remain independent in the home and move around as they wished. There were coded locked doors at each floor exit and the exit to the building. Lifts situated in the centre of the home were also operated by coded locks. We asked people if they were aware of the codes to use these exits if they wished to move to another area or leave the building. None of the nine people we spoke with knew how to exit these doors without staff assistance. They told us, "I don't know but I would like to go out and look at the shops." Another person said, "We are not allowed to go off the floor without help. I think they could let us go out and have more freedom." A relative told us, "They [people] haven't got the code." People were not able to access areas of the home independently and could not leave the home without support from staff. There were no records to identify this had been discussed and agreed with people or their representative. No consideration had been made as to the restrictions this may have been having on people. The manager and provider told us people could have the codes to the doors if they requested them.

Staff had not applied the principles of the MCA to ensure people received the care and support they required in line with their wishes and best interests. Records showed only two of eleven staff members had received training in the use of the MCA and Deprivation of Liberty Safeguards (DoLS). Staff had a limited understanding of the MCA and the impact it had on their work. One told us, "We must always ask permission from them before we help them. If they refuse then I must not do it."

The lack of adherence to the MCA 2005 was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a low number of staff which gave people continuity in the care they received. Staff demonstrated a good awareness of people's preferences and needs. An induction plan was completed for new staff when they commenced work at the home. A programme of training was available to all staff to ensure they had the skills required to meet the needs of people. The provider monitored this programme to ensure all staff completed training and updates in accordance with the provider's policy. Most of this was based around DVD training followed by a questionnaire to check understanding of the information. Staff told us they had received the training they required to meet the needs of people; however records of training achieved and completed by staff lacked detail and did not always reflect the training people told us they had received.

A system was in place to support staff development through the use of one-to-one sessions of supervision and appraisal; however this was in its infancy. The manager told us this would ensure staff received up to date training

Is the service effective?

which was monitored and reviewed, information on the service as it developed and would give staff the opportunity to discuss any concerns or learning needs they may have.

Staff ensured people were provided with suitable and nutritious food and drink. People enjoyed the food provided and always had enough to eat and drink. People were offered choice at each mealtime and the chef had a good awareness of people's preferences. Special diets could be catered for such as soft, diabetic and vegetarian diets, although none were required at the time of our inspection. Food was presented well in an environment which was clean and fresh. In a dining area on the first floor of the home staff regularly prepared hot drinks for people and breakfast was served from there.

People had access to external health and social care professionals and services as they were required. The community nursing team visited the home regularly to support staff with health care issues including wound care and reduced mobility. For example, two people had received support with exercises and mobility practice following surgery. Staff had not required the assistance of many other health care professionals however were aware of how they could do this.

Is the service caring?

Our findings

People were very happy with the care and support they received. Staff knew them well and people said staff were very kind and caring. Comments we received included; "The carers are all very nice and helpful," and, "All are friendly, the staff and people. Nice and gentle, no rough ones." A relative told us, "They have done wonders for [person], they really care for [them] well."

Staffs knew people well and were aware of people's preferences and mannerisms. For example, one person loved to be busy and get involved in housework or washing up. Staff supported them to be involved with this. For another person who became distressed and tearful, staff took time to provide them with privacy and listen to their concerns. The person calmed quickly and staff reassured them and offered them comfort. Staff provided a respectful and caring environment in which people's dignity was respected and people enjoyed living.

People were encouraged to personalise their room and several rooms were decorated with memorabilia of the person's life. The manager told us they were looking to encourage and support the use of all areas of the home and create a community spirit for people who lived there. Whilst there were only a small number of people in the home, the manager and provider had recognised the premises were not used to their full potential. They had invited people to the service from the local community to join in a film afternoon. One person told us this had been, "Very entertaining and nice to let people see our lovely home."

People and their relatives were involved in making decisions and planning their own care. For example, one person told us how they were supported by external health care professionals to complete exercises to improve their mobility. They told us this had been discussed and agreed as a care need with staff at the home. For another person, whose health had declined since their admission, staff had engaged with relatives and the person to reassess their needs and review the care they required. A relative spoke of the swiftness of staff response when they requested a change in the support for their loved one. "They are great, can't do enough for [person]."

People and their relatives /representatives were encouraged to communicate with the manager and staff at any time. Daily care records showed relatives spoke with staff during their visits and information was shared with them, as agreed with the person, about the care their loved ones received. The provider had held one meeting for people and their relatives to allow people's voices to be heard. Regular meetings were to be planned.

Is the service responsive?

Our findings

People felt able to raise any concerns they may have about the service with staff, the manager or the provider. People said, "Oh yes, I'd speak to any of them, they are all very approachable. Relatives told us staff were very approachable and always happy to have suggestions in support of their relatives care and welfare. One said, "I would have no hesitation talking to the staff about any concern I had."

Each person had an individual plan of care. On admission to the home, information had been sought from people, their families and representatives to gather a history of their life and personal preferences. This information had helped to inform care plans for people which included; mobility, dietary and nutritional needs, emotional and psychological needs, sleep routines, communication, continence and personal hygiene needs.

Care plans were personalised and held some information on the support people needed. Some care records lacked consistency and clear information to ensure people received the individualised care and support they required to meet their needs. For example, one person had a health condition which required them to take medicines to thin their blood. The side effects of this medicine could have caused severe bruising or internal bleeding. Care plans did not identify this condition or the needs associated with it for this person. Following their review of care plans in the previous month, the manager told us they had implemented a new format for care records which would support a more comprehensive record of people's care. These care plans would include the views of people and their relatives and be agreed with them. We saw this format was being been added to two care records and supported more robust plans of care which identified people's needs and how staff should support them to meet these. Daily records were maintained by staff to record the activities people had participated in during a day and the support and care they had required.

People and their relatives had been invited to a first meeting on 21 January 2015 to discuss their views of the home and how it was managed. Actions from this meeting had been agreed and taken forward by the provider and manager. For example, suggestions had been made of different activities to be added to the choice available. One of these was for a pet to come along to the home. On the day of our visit we saw this happened. Further visits were planned.

There was a large communal area on the ground floor of the home which contained many areas of interest and resources for people including; hairdresser, sensory room, secure outdoor garden, games, memorabilia, cinema, conservatory and general areas where people could relax. This area was not accessed by people during our visit. People told us they did not access this area very often, however could not tell us why. Staff said people were offered choices to use other areas of the home.

People gathered in a smaller communal area on the first floor of the home. They were encouraged to participate in an activity of biscuit decorating with care staff. A program of activities available was not regularly followed. Staff told us this was because people often chose not to be involved in the planned activities and with the number of people currently at the home, people could enjoy each other's company in one area or complete another different activity. We saw this choice was reflected in the notes from the meeting with people and their relatives, where people made suggestions of activities they would like to participate in and these were supported. Care records showed people were regularly supported to complete an activity of their choice such as sorting washing, washing up and art activities.

The provider had a robust complaints process in place which was clearly available for people. They had received no formal written complaint since opening. People were happy to raise any concerns they had with staff or the management of the home and felt sure their concerns would be dealt with promptly. During our inspection we saw the manager responded promptly and effectively to any concerns raised and was well known to people who lived and worked at the home. A relative told us of an issue they had raised and how it had been dealt with promptly.

Is the service well-led?

Our findings

People felt the provider, manager and their staff provided a good, safe and effective service. Staff enjoyed working at the home and told us, "I enjoy it here. I like having time to care properly," and, "We want to be the best." Relatives told us the management team were easy to talk to and always available.

The home was registered as a nursing home. There were no people who required continuous nursing care at the home. No registered nurses were employed at the home at the time of our visit. We asked the manager and provider what plans they had in place to ensure people admitted to the home with nursing needs would be met. They told us they would ensure sufficient registered nurses were available to meet people's nursing needs before they were admitted. The provider did not have in place a system which allowed them to identify the dependency and needs of the people who lived at the home and how this altered as new people were admitted. The manager told us they had identified this need.

A programme of audit and review of the quality of the service being provided for people was completed on a monthly cycle by the manager and was supported by the provider. These audits included; infection control, health and safety, food hygiene, care plans and environmental audits. The audit of care records had identified the lack of details and consistency in records and also the lack of information about people's capacity to consent to care and treatment. These areas were being addressed.

The manager and provider knew people who lived and worked at the home very well. They told us they promoted an honest, open and transparent workplace where people were valued for themselves. This was reflected in the way staff and people at the home interacted and enjoyed a calm and peaceful environment. The manager and provider were very visible to staff and people who lived at the home and were easy to communicate with. They offered support and direction whenever it was required.

Staff meetings were organised and staff told us these provided information on procedures, training, complaints and information for staff on people new to the home. They were also able to discuss any other issues they may have. They had a good understanding of their role and how to report any concerns to senior staff or management. The staffing structure supported effective reporting of concerns by staff.

Staff training records showed many areas of mandatory training which had not been completed, although staff told us they had received training to meet the needs of people who lived at the home. For example, records showed of 11 staff members; six had not received training on safeguarding, four had not received training on moving and positioning of people, seven had not received an induction. Whilst we were assured people had received training this was not clear when this had been completed.

The manager had a system in place to monitor all incidents, accidents or areas of concern identified at the home; there had been no significant incidents recorded. They told us how they would ensure information would be shared with people and staff as appropriate following a thorough investigation into any concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that was inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided. Where consent could not be provided best interests decision making had not been done.