Senex Limited

Bloomsbury House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bloomsbury House is a residential care home providing personal to up to 24 people. The service provides support to people living with dementia. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
People were not always protected from the risk of harm; we found systems were not effective in reducing risks to people, particularly through monitoring and seeking external support for health needs. Systems in place to safeguard people from abuse were not robust and processes for learning lessons were not effective in driving improvements.

People were not supported to have maximum choice and control of their lives and staff did not 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.

Quality assurance systems were not effective for people. This meant the action taken by the provider had not ensured people received consistently safe and high-quality care. Shortfalls identified at the previous inspection had not been remedied by the provider.

People's preferences and person-centred needs were not always fully considered and met. Group activities were facilitated by the service, but some people spent long periods without any social interaction.

People were mostly treated in a caring and compassionate way, by staff who knew them well. However, the systems in place did not always facilitate a caring experience for people. People's independence and ability to make personal choices was not always respected.

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 30 April 2021).

We imposed conditions on the registration of the provider, with a view to ensuring the service made improvements towards meeting the regulations. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about how people were supported with moving and handling, how people's health needs were managed and how people with dementia were safely supported. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to how people's safety was managed, how people were safeguarded from abuse, their rights promoted, people being treated with dignity and respect, how people's person-centred needs were met and how the service was run at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Bloomsbury House

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 Health and Social Care Act 2008.

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
The inspection was carried out by 1 inspector, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Bloomsbury House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Bloomsbury House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people and 4 relatives about their experience of the care provided. We spoke with 6 professionals who have contact with the service. We spoke with 8 members of staff including the registered manager, senior care staff and care staff.

We reviewed a range of records. This included 6 people's care plans and a range of medicine administration records (MAR). We viewed a variety of records relating to the management of the service including audit systems. We spent time observing the care that people received within the home.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

At our last inspection we found the provider's risk assessment processes were not always effective. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were not assessed and monitored for weight loss or malnutrition. The provider did not have adequate equipment for weighing people. Systems were not effective in ensuring people were monitored regularly and actions taken in response to changes in weight. Whilst the provider purchased chair scales following our feedback, action was not taken to seek medical advice and support dietary intake when the new equipment showed some people had experienced significant weight loss.
- Medicines were not always safely managed. People were not always supported by staff who had been trained in medicine administration. Staff who administered medicines did not have their competency regularly reviewed. This put people at risk of harm through the mismanagement of their medicines.
- People did not always have protocols in place for 'as and when' (PRN) medicines. Where protocols were in place the information about their use was not always clear. This meant people were at risk of not receiving these medicines appropriately.
- People who were prescribed PRN laxatives were not monitored for signs of constipation. This meant that people who could not monitor their own bowel movements were at risk of prolonged constipation and discomfort.
- The environment was not always safely managed. We observed some fire doors were routinely propped open. Chemicals were left in reach of people during our inspection. The provider took action to address these issues following our feedback.
- People were not always supported by effective infection control practices. We observed some equipment in bathrooms was soiled and there were shortfalls in infection control measures in the premises. Some staff had painted nails or wore jewellery. This put people at risk of the spread of infection.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider took immediate actions to address these shortfalls, following our feedback.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse. We found 2 allegations of physical abuse had not been thoroughly investigated and reported to the local authority safeguarding team. This put people at risk of ongoing harm.

● People who experienced distress as a symptom of their dementia were not always protected from excessive use of medicines to control their movements and behaviour. People's distress was not monitored to record changes and to justify requests to medical professionals for antipsychotic medicines. This put people at risk of disproportionate use of medicines as a form of restraint.

● Staff had not always completed recent training to safeguard people from abuse. Records showed approximately half of the staff team had completed this mandatory training. This put people at risk as staff may lack the skills and knowledge to escalate any signs of abuse.

The provider had failed to take action to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Learning from previous accidents and incidents was not always gained, to protect people from ongoing harm. The system in place to review this information was not effective and was not consistently completed. This meant opportunities to mitigate ongoing risks to people could have been missed.

● At the previous inspection we found the provider did not have effective systems to reduce risks to people, such as ensuring referrals to health professionals were made, or ensuring people's needs in the event of a fire were assessed. We imposed conditions on the provider's registration to support improvements in these areas. During this inspection we found the provider had failed to learn lessons from the previous inspection and our resulting enforcement action.

Staffing and recruitment

● Staffing levels were maintained at the assessed level to support people safely. We saw there were adequate staff available to meet people's needs during our inspection. Where people asked for help, they were supported in a timely way.

● The service had an established staff team, with many staff members working at Bloomsbury House for several years. This meant the provider did not have to use agency staff and people were supported by staff members who knew them well.

Visiting in care homes

The provider was facilitating visits for people in the home. During the inspection we observed several relatives and friends visiting their loved ones.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection we found the provider had failed to make the appropriate referrals to relevant health professionals in order to ensure people were receiving the correct care and treatment to meet their needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider failed to work with external professionals to ensure people received treatment that met their needs. For example, 1 person was not supported to have a reassessment of their moving and handling needs, when there had been a longstanding change in their mobility. This put people at risk of harm.
● Changes in people's health needs were not always escalated for medical advice appropriately. The provider failed to recognise people's significant weight loss and seek a medical opinion. This put people at risk of a decline in their health and malnutrition.
● Where medical professionals had given advice for people's care and treatment, this was not always followed. We found occasions where advice for health monitoring or suggested medicines were not followed up. For example, we found 2 instances of an unacceptable delay in seeking prescribed medicines for people.

● Some professionals advised that communication with the provider was poor, and professionals lacked confidence that the service would access healthcare services for people in a timely way. Some professionals raised concerns about how people were monitored by the provider.
● Care plans and risk assessments were not always in place for people's individual needs. Where these documents were completed, they did not always contain the relevant information or were reviewed following changes to a person's needs. For example, we saw one person's falls risk assessment had not been reviewed following a fall.

The provider had failed to work with external professionals to ensure people received timely care planning for their health, safety and welfare. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider did not always seek DoLS authorisations for people where there was indication they could not consent to restrictions on their liberty. We found indications that authorisations should have been sought for 2 people; this put them at risk of an unauthorised infringement of their rights.
● The provider did not have an effective system for recording when a DoLS authorisation had been applied for or granted. This meant we could not always be assured authorisations had been sought in a timely way. The registered manager took steps to address this during the inspection.

The provider failed to ensure people were not deprived of their liberty without the lawful authority to do so. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found shortfalls in people's consent or best interest decisions being conducted and recorded. At this inspection we found a continued lack of documentation that people's consent had been sought or a decision had been made in their best interests.
● People's capacity to make personal choices was not assessed for the specific decision needing to be made. Where people were deemed to lack capacity, this was recorded as being for all decisions. This was not in line with the MCA and meant that people may have been prevented from making their own decisions where they were able.
● People who had been assessed to lack capacity did not have best interest decisions detailed in their records. This included where people were subjected to restrictions, such as supervision while walking through the home.

The provider failed to systematically seek consent from people about their care and treatment. Where people lacked capacity, the provider failed to follow the legal framework of the Mental Capacity Act 2005, to reach decisions in people's best interests. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Not all staff had received up to date training in a range of relevant subjects. For example, a significant proportion of the staff team had not completed safeguarding adults training, MCA and DoLS or prevention of falls training. This may have contributed to the lack of staff knowledge, such as the failure to recognise safeguarding matters.
● Staff practice was not regularly monitored through competency assessments. This meant practical skills

such as medicine administration and moving and handling were not reviewed to ensure people were supported safely.
● New staff received an induction. Staff members told us they felt well-equipped to carry out their roles. One staff member stated, "The training and induction opened my eyes… for me, I don't just want to tick the boxes, I want to learn more and understand more."

Supporting people to eat and drink enough to maintain a balanced diet
● People who were at risk of malnutrition were not monitored appropriately to ensure they received adequate nutrition and hydration. For example, a medical professional had requested that 1 person's oral intake was subject to monitoring, but the provider had failed to carry this out. This put people at risk of further weight loss and a deterioration in health.
● The kitchen staff had a clear system for recording people's dietary requirements and had good knowledge of people's likes and dislikes. We observed people were offered drinks and snacks throughout the day and alternatives if they did not like the meal options.

Adapting service, design, decoration to meet people's needs
● Elements of the premises were not always dementia-friendly, and some areas were showing signs of wear and tear. For example, more could be done to support people to orientate throughout different areas of the home using colours and signage.
● Parts of the environment at Bloomsbury House had been considered to meet people's needs. For example, there was a quiet room for people who preferred to sit without distractions such as the TV or radio. There was a purpose build garden room that was decorated brightly with people's crafts and people enjoyed spending time there.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Respecting and promoting people's privacy, dignity and independence

- People's independence wasn't always supported. One person told us how they used to be supported to use the toilet, but this was not offered anymore. They said, "They [the staff] don't do it anymore… I've asked before but they've told me just to do it [in my incontinence pad]."
- Whilst individual staff members were reported and observed to be caring, we found some aspects of the care being provided to people were not always caring. The concerns around people's weight management and the escalation of safeguarding matters identified throughout the inspection showed that consideration had not always been given to the safety and experience of people living at the home, including their quality of life.
- Although care plans and risk assessments in place did not always include clear guidance for care staff to follow, staff knew people well.
- People and relatives told us staff treated them well and were kind and caring. One relative told us, "Staff are very kind. They respect [my loved one's] privacy. When [my relative] needs changing, they explain what they are doing. If we are there, we are asked to leave the room."

Supporting people to express their views and be involved in making decisions about their care

- Systems were in place to seek feedback from people and relatives about the quality of the service they received.
- Whilst records highlighted that people were not always fully involved in decisions about their care, people and relatives found the registered manager approachable and felt able to raise any day to day concerns they had about the service.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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

- People did not always have full choice and control over their day-to-day routines and activities. We found instances where people's expressed wishes and preferences were not respected. For example, one person's wishes regarding their personal care and moving and handling were not being met. This meant people did not always receive person-centred care.
- The provider did not always design people's care in line with their needs and preferences. We found care planning was not always completed for people's specific needs. For example, 1 person's care plans were largely blank, despite being at Bloomsbury House for several months.
- Some people did not have specific care plans for their individual needs. For example, people's records did not contain oral care plans. People who had specific health issues such as diabetes, skin wounds or mental health issues did not always have individual care plans to consider their person-centred needs.

The provider had failed to ensure people had maximum choice and control over their needs and preferences. 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 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People had care plans in place to consider their communication needs. However, these were not always effective or respectful. For example, 1 care plan for a person who had dementia stated, "I don't make much sense when I speak, I muddle all my words."
- People were supported by staff who understood their communication needs. We observed staff knew people's communication needs well and engaged with people on their terms.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported by an activities coordinator who organised person-centred group activities, which people appeared to enjoy. One relative said, "There are activities such as drawing which [my family member] enjoys. At home [my relative] was bored stiff."

● Outside of set activities, people sometimes spent long periods of time alone or without engagement. This put people, particularly those who were cared for in bed, at risk of social isolation.

Improving care quality in response to complaints or concerns

● The provider had a system in place to record, investigate and respond to complaints received.

● Feedback from people, relatives and professionals was sought. The results from questionnaires were analysed and actions in relation to the findings were documented.

End of life care and support

● People had care plans in place to consider their individual wishes, values, and beliefs at the end of their lives. At the time of the inspection no one was being supported with end of life care.

● The provider worked closely with an external organisation and met weekly to discuss people at the home and consider planning for those who may be nearing the end of their lives.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 we found the provider had failed to ensure effective systems were in place to ensure they had good oversight of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- During the last 2 inspections of Bloomsbury House, we identified that whilst the provider had systems in place to monitor the quality of the service, these had not always identified some of the shortfalls we found during the inspection in relation to record keeping. We found this to still be the case during this inspection and the service had not improved.
- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service. For example, the provider failed to implement robust systems to monitor people's health needs and the safety of the environment.
- Governance systems were not effective in ensuring action was taken when shortfalls in the service were identified. Following the previous inspection, the provider was required to send monthly reports to CQC about how improvements towards meeting the regulations were being made. This inspection identified the provider was still in breach of regulations.
- Systems and processes were not effective in ensuring allegations of abuse were recorded, reviewed, investigated and, where appropriate, reported to external agencies. Systems for reviewing accidents and incidents were not effective in identifying potential learning.
- Governance systems failed to ensure people were not unlawfully deprived of their liberty by applying for DoLS authorisations in a timely manner. Systems were not effective in ensuring people's consent was sought for all aspects of their care and treatment.

Systems and processes were not established to ensure service users received safe, quality care that met their current needs. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We spoke with 6 professionals who worked with Bloomsbury House. Several professionals shared concerns about the safety and quality of the service people received. One professional stated that communication with the provider was poor and they did not have confidence that improvements would be made.

● The service had an established staff team who spoke positively about the provider and working at Bloomsbury House. Staff felt able to approach the registered manager with any issues they were having.

● Systems were established to seek feedback from people, relatives and visitors to the service. We saw previous feedback had been analysed and was positive about the service people received.

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

● The registered manager understood their responsibility of duty of candour. Notifications were sent to CQC about key events as required.

● Staff were aware how to raise any concerns if they were to arise and felt confident to escalate their concerns should they need to.

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 The provider had failed to ensure people had maximum choice and control over their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.