Four Seasons Health Care (England) Limited

Belle Vue Care Home

Inspection report

8 Belle Vue Road,
Paignton.
Devon.
TQ4 6ER
Tel: 01803 522112
Website: www.fshc.co.uk

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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 caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was unannounced and took place on 10 June 2015.

Belle Vue is a purpose built care home registered to provide care for up to 52 people. The home is set over three floors. People living at the home are mainly older people with very significant care needs. The ground floor provides accommodation for people with physical frailty, some of whom may also be living with dementia. Senior staff told us that the first floor of the home was a specialist unit for people with dementia, although this was not identified in the brochure of the service that we were given.

We identified a number of concerns about the operation of the home on this inspection. Overall we found that there were greater concerns about the operation and quality of the first floor dementia nursing care unit than the ground floor general nursing care unit.

The home has a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were not always protected against risks at the home, as some risks to people's health and safety had not been identified or sufficiently well managed. These related to supporting people with behaviours that challenged or presented risks to themselves or others, and were mainly on the dementia care unit. Other risk assessments, for example those related to helping people with moving and positioning on the general nursing care floor had been completed, and people were being moved safely, using appropriate equipment.

Staff told us they would report any concerns they had about people's well-being to the home's management, although not all could speak confidently about what to do to involve external agencies in investigating concerns.

People were not being protected by the home's recruitment processes. The registered person had not ensured a robust recruitment process had been followed or recorded for all staff.

People told us they felt the home was short of staff. We saw that around once a week the night staffing rota showed there was one person less than the assessed level needed to meet people's needs. Staff on in the day had little time to spend talking with people.

People were not always being protected from the risks associated with medicines. Some care staff were administering medicines on behalf of registered nurses without protections in place. Staff were not always implementing infection control measures properly, so some areas of the home were not cleaned effectively and did not smell fresh.

Although we saw some good practice on the ground floor general nursing care unit, staff did not always have the skills or knowledge to support people effectively, in particular on the dementia care floor. The systems for staff supervision and appraisal were not being used consistently or effectively in either unit to support staff develop and improve their skills.

People's rights were not being protected as the home had not applied for the appropriate authorisations to deprive people of their liberty or delivered people's care in line with the Mental Capacity Act 2005.

.People in each unit received a balanced and nutritious diet, including those people in the general nursing care unit who needed their meals pureed or softened. However, people's dietary and fluid intake was not being monitored effectively. This left people at risk of poor nutrition or hydration. The registered manager had already identified this and was taking action to provide a new monitoring form.

Care plans did not always reflect people's needs and wishes, or the actions staff needed to take to meet people's needs. On the dementia care floor staff did not always support people to engage with their environment, and did not identify the provision of positive activity as something for all staff to be supporting people with throughout the day. On the general nursing care floor, we saw staff speaking to people in a caring manner, and being supported well with their care. People received good access to community healthcare services and support, including access to community services.

People were not always being protected from poor quality care through the processes for audits and quality assurance. Some of the concerns we identified in this inspection had been identified in quality assessments undertaken by the provider organisation, but actions had not been completed to rectify them. Others had not been identified. Some audit systems had been used effectively to improve people's care, for example in reducing the risk of falls.

People told us the registered manager was accessible and approachable. Efforts were being made to increase opportunities for people to give their feedback about the home and the quality of their experience. Feedback we received from people who visited the home or supported people who lived there was very positive.

We found a number of breaches of 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?

Requires improvement

The home was not always safe.

Risks to people had not always been fully assessed or guidance given on how to reduce or manage risks.

People were not being protected by the home's staff recruitment processes.

People told us there were not always enough staff. We found there were enough staff to provide basic care for people, but limited time was available to engage with people, particularly where people needed extra support to achieve this.

People were not protected by the systems for the management of medicines.

Although not all staff were confident about safeguarding people, they told us they would report any concerns they had about people's well-being.

Is the service effective?

Requires improvement

.The home was not always effective.

Staff did not always have the skills or information needed to support people.

Systems for staff supervision and appraisal were not effectively or consistently used to support staff to develop and progress their skills.

People's rights were not being protected as the home had not acted in accordance with the Mental Capacity Act 2005 or Deprivation of Liberty safeguards.

People received food that was nutritious and well presented. People's food and fluid intake was not being monitored well enough to ensure people received the nutrition and hydration they needed.

Is the service caring?

Requires improvement

The home was not always caring.

Staff did not all know people's histories or backgrounds. Much of the engagement between staff and people was about tasks, but where we saw staff speaking to people it was done in a caring manner.

People were not always supported to present themselves in ways that supported their well-being.

People were not always involved in making choices or maintaining their independence.

Is the service responsive?

Requires improvement

The home was not always responsive.

Summary of findings

Care plans did not always reflect people's needs and wishes, or actions staff needed to take to meet people's needs.

People did not always receive support to undertake appropriate activity or receive stimulation to meet their needs and wishes.

Is the service well-led?

Requires improvement

The home was not always well led.

Systems for assessing the quality of the service had not always been effective in identifying concerns or improvements needed. Where concerns had been identified some of the actions to improve outcomes for people had not yet been implemented.

The registered manager was available and accessible to people. People told us they found her approachable.

Belle Vue Care 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.

This inspection took place on 10 June 2015 and was unannounced. It was carried out by two adult social care inspectors 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. In this instance the expert had experience of supporting someone with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home.

Belle Vue Care Home is organised over two floors. The ground floor was used for people with physical or general nursing, and the first floor was being used for people living with dementia or mental health needs. The first floor unit was locked.

On the inspection we spoke with or spent time with five of the 23 people who lived in the ground floor unit, three visitors and three members of staff. We also spent time with five people on the first floor unit and observed the care delivered to others, spoke with five visitors, four staff and a volunteer visitor from the local church. We also spoke with the registered manager, regional manager who came to the service as a representative of the provider, and the head of care for the mental health unit.

Most people who lived at the home on either floor were not able to share their experiences with us verbally as they were living with significant dementia or physical frailty. We spent several short periods of time carrying out a SOFI observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us. We contacted the local commissioning and quality team prior to the inspection to gather their views about the service.

We looked at the care plans, records and daily notes for eight people with a range of needs, as well as other records in relation to the operation of the home such as risk assessments and policies and procedures. Following the inspection the manager sent us additional information we had requested or that could not be located at the time of the site visit.

Requires improvement

Is the service safe?

Our findings

The home was not always safe. We identified concerns in relation to risk assessments and risk management, recruitment, staffing, management of medicines and infection control.

People were not always being protected from risks presented by the premises or related to their care needs. For example we asked to see the risk assessments and checks on window restrictors. This was because there was a newly identified risk in relation to one person who had been recently admitted to the dementia care unit. The person's care plan indicated an awareness of the risks presented, but the care plan was very sparse and did not contain enough information to help staff understand the risks, or what actions staff should take to mitigate the risks. There was no individual risk assessment in the person's file in relation to risks presented by their behaviours, and no evidence that checks of the restrictors in place had been carried out as a result of the change in risks presented.

Some people in the dementia care unit presented with behaviours that were challenging or might present risks to others. Their care plans did not contain sufficient guidance for staff on the actions to take to help protect the person and others in a consistent way. For example we asked a senior staff member to identify a person who presented behaviours that were challenging. We then looked with them at the person's care plan. This plan identified the risks presented by the person's behaviours; however there was not sufficient information on the actions for staff to take to mitigate the risks to the person or others in a consistent way. A senior staff member told us that staff would use 'distraction techniques', but there was no detailed guidance in the file about what this meant for this individual to de-escalate or minimise risks to others. We saw this person regularly challenged other people living at the home. On some occasions staff intervened, on other occasions they were not present when the challenges occurred. This told us that the person was not always consistently supported or the risks they presented to others managed consistently.

The management of the home had not taken adequate and clear action to protect people from known risks or harm. This was a breach of Regulation 12 (1) (2) (a) and (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other areas of risk were assessed and managed well. For example, we saw that people had risk assessments in place for moving and handling practices. We observed staff in the general nursing care unit moving a person using equipment, and transferring another person using a wheelchair. We saw this was done well, with the person being spoken to and involved throughout the process.

A recruitment process was in place that was designed to identify concerns or risks when employing new staff. We randomly sampled five staff files, and identified concerns with two of these. Certain risks had not been identified or addressed by the recruitment process, for example, one staff member's application process contained discrepancies in their employment history and references. There was no written evidence that these had been identified or discussed with the staff member concerned. References for this staff member did not relate to their most recent employment in care work, but to previous employment in another sector. It is a requirement of legislation that prior to employment the registered person gains satisfactory evidence of the 'staff member's conduct' in any previous employment in health or social care and of the reasons why they had left.

Another person's pre-employment checks had identified a potential risk. The registered manager told us that they had discussed the concerns with the person and considered the risk would not affect their employment. Although the risk was not high we could not see written evidence that the manager had reviewed or assessed the risks.

The failure to follow a robust recruitment process is a breach of Regulation 19 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Five out of the eight relatives we spoke with told us that they did not think there were enough staff. They said "There's not enough staff…all the patients are very needy and they could do with a few more on every shift" and 'My only criticism is insufficient care assistants, particularly at night.' Staff told us that "If everybody is on shift there are enough staff".

Observation in the first floor dementia unit showed staff time was taken up by tasks, and we did not see any staff engaging for more than a passing few seconds with individuals for much of the day. When they did, this was often to intervene between people who were expressing challenging behaviours rather than in a positive way.

Requires improvement

Is the service safe?

A number of residents in the dementia unit were not dressed or washed until near lunchtime. We were told this was because people were 'exercising choice', and did not always want to receive care when it was offered. However, we did not find evidence that this was a matter of choice for people or that staff kept returning to people to go back and help them to dress. We also saw instances where people were not observed when at potential risk. For example, one person was given porridge and then told "eat it slowly it is very hot" and left to eat unsupervised. They ate very quickly.

The manager used a staffing assessment tool to analyse the level of staffing needed in the home. On the day of the inspection we saw that the night staffing compliment had been one less than the staffing tool had identified was the needed level. This had left two registered nurses and three care staff on duty for 50 people, when the assessed needed staffing compliment was a registered nurse and two carers in each unit.

Rosters and payroll records for the five weeks prior to the inspection showed that at night the home had three care staff on duty on average once a week. The registered manager said the staffing issues usually resulted from staff going off sick at short notice, and despite attempts to cover, this was not always possible. On the night prior to the inspection visit staff had been deployed so that there was one nurse and one carer in each unit, with the third carer floating between floors to provide cover at peak periods of activity to minimise the disruption.

Staff had received some training in safeguarding, and showed some awareness of the principles and actions to be taken to help safeguard people. But not all staff spoke with confidence about what to do to protect people. A staff member told us there used to be a 'whistle blowing' number up on the wall but they could not locate it. We informed the manager of this.

Evidence showed staff had either undertaken or were due to undertake training in safeguarding. This was delivered via an e-learning system as well as face to face training, as the manager had recognised that the e-learning programme was not always the most effective method to ensure that staff learned from the training. Where concerns had been identified the registered manager had taken appropriate action to report the concerns to external agencies.

Staff told us that they would report any concerns about abuse they had to their unit head or the manager of the home. For example staff told us "If I was worried I would speak to a colleague and if they agree we'd speak with a senior", and "I'd go straight to the head of the unit and inform them".

People were not always being protected against the risks associated with medicines. The home did not as a matter of policy check with a person's GP when a person was admitted to the home from another care setting or hospital to check the information on medicines they had received was accurate. This meant it was possible for changes in a person's medicine regime not to have been recognised.

"As required" medicines were recorded, for example painkillers to be given to people only when needed. However there were no clear individual protocols for the administration of medicines prescribed to manage people's behaviours or mood. We discussed this with senior staff who agreed they did not have the information but told us "The staff know (person's name) well. They will pick it up". One person had received 'as required' medicine to manage their behaviours regularly in a week prior to the inspection. There was no identified reason on the medication administration record (MAR) or in their notes as to why this had been given, or what else had been tried prior to the administration of the medicines.

Medicines were given out by the registered nurses on duty in each unit. Some medicine was signed for on the MAR as being given by the nurse but was handed to care staff to give to people in their food. We observed this being carried out by care staff, who added a powdered laxative to one person's drink. We saw the person was not observed while they took the drink. The nurse had signed the MAR to say the medicine had been given. We were told that the nurse only gave medicines to 'trusted people' to administer on her behalf. We were concerned that there was no monitoring of the person taking the medicine which could easily have been taken by another person for whom it was not prescribed, and there was no way for the nurse to assess if the person had taken all the medicine or not. Charts were kept in people's bedrooms for creams and topical medicines. However these had not always been completed.

Instructions for staff on the use of prescribed medicines were not always clear or consistent across documentation. We saw for example that one person's record was signed to

Is the service safe?

state that they had cream applied four times a day. However the cream was not identified on their topical medicines chart. They also were prescribed a thickening agent for fluids as they were at risk of choking. There was no indication as to the required thickness of the fluids on either the MAR or on the medicine which just indicated “as directed”. We asked a member of staff about the required consistency and were told "Thick not thin”. This would not be sufficient information to ensure that staff used this consistently.

We found that the service had placed people at risk because staff did not handle medicines safely. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

.Records were kept of medicines received into the home and of their administration on the MAR. Where there were variable prescriptions for example, such as take one or two tablets, the number taken was recorded. We saw a nurse supporting a person to take their medicines on the general care nursing floor. We saw the person was given information about the medicines and time to take them at their own pace.

Not all areas of the home smelled clean or fresh. Areas of the home had an odour problem which was present at 7am and still there at 7pm. An infection control audit had been carried out in January 2015, and training delivered in infection control to the staff team in September 2014. Staff wore aprons to serve food and aprons and gloves when supporting people with their care.

Risk assessments were being carried out of the premises. This included assessments of the safety of hoisting equipment, fire precautions, health and safety assessments, bacterial contamination of water supplies and water temperatures. There were emergency plans in place for the operation of the service, evacuation plans and contact numbers for staff in case of emergency. The home had received a 5 out of 5 rating for food safety from the environmental health department in 2014.

Plans were in place to manage emergencies. First aid kits were available on each floor, and emergency evacuation instructions and personal evacuation plans were situated in the front hallway.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. We identified concerns in relation to staff skills and knowledge, supervision and appraisal, implementation of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, recording of people's food and fluid intake, and the adaptation of the environment to support people with dementia.

Staff did not always have the skills to support people effectively or consistently. Although records showed the staff received training for their role, we saw evidence that this training was not always put into practice. For example we saw an incident at lunchtime when three people were seated at the lunch table in the dementia unit. Due to the way the staff served the meals one person was given their meal some time before the other two. This led to the meal being taken and eaten by another person with their fingers before their first person could eat the meal. Staff then tried to give the meal back to the first person half eaten, before we intervened.

We saw another staff member supporting a person to eat in their room on the general nursing floor. This was done sensitively and confidently, with the staff member putting on music of the person's choice and enabling them to sit in an appropriate position. They engaged with the person throughout and the person ate well.

On the dementia care unit we saw staff quickly and skilfully distract one person from a potential altercation with another person who was living at the home, but we saw other instances where staff failed to identify, engage or defuse issues quickly and appropriately. For example we saw one person become distressed while walking in a corridor, and was calling out for staff. A member of staff came past and asked them to move with their frame without acknowledging the person's distress or communicating with them effectively.

Relatives told us they were very happy with the care people received. One said they had chosen the home "because of its size. It has plenty of nursing care around the clock, whereas I felt smaller homes would not have the same level of care; the building is highly modified and adapted to suit its purpose and it's good for wheelchairs…at one point (person's name) swallowing reflex went and staff administered medicines in liquid form and pureed her food'. Another told us "We're very, very fortunate that she came here after an assessment at Exeter…it's very, very good."

Staff received supervision and appraisal, but records of these did not show that they were based on encouraging staff development to improve their performance. Some supervision records were sparse. Senior staff who carried out supervisions told us that they only kept detailed records if they had concerns about the members of staff performance. However we found one staff record which stated the member of staff needed to improve. The area for improvement had not been identified and there was no record as to how the member of staff would be supported to improve or a record of review or evaluation. The registered manager agreed there were inconsistencies in the way that supervisions and appraisals were carried out by different staff.

The home had a training matrix that covered both training for general care needs such as first aid and moving and positioning training along with more specialist training for specific people's needs. Staff told us they received the training the needed. One staff member said "There is tons and tons of training here, each person has a training folder, 26 / 27 e-learning topics we have to do each year, and then there's manual handling and thing you have to have practical (training) on". Staff completed an induction including shadowing more senior staff, and newer staff will commence with the new care certificate for induction.

People's rights were not protected as the provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards. Staff we spoke with were not clear about MCA or DoLS. Some staff thought that there were people at the home subject to DoLS authorisations but did not know what that meant. Others knew there was no-one that the home had an authorisation to lawfully deprive of their liberty. But staff again were not clear what the implications of that were for the people who lived there, for example if the person tried to leave the home. This told us that staff did not understand what they must do to comply with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they

Requires improvement

Is the service effective?

do not have the capacity to make certain decisions and there is no other way to look after the person safely. Applications had not always been made for Deprivation of Liberty Safeguards authorisations where people were considered to be deprived of their liberty. The first floor unit was locked, and we were told that no-one there would be able to go out unescorted. People in this unit were under continuous staff control or observation. Applications for Deprivation of Liberty Safeguards had not been applied for, for all the people living on this floor. The failure to apply for this for all people affected meant that the home may be depriving people of their liberty unlawfully.

This is a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments had not always been made on either floor of people's capacity to consent to care and treatment, or record 'best interest' decisions made on their behalf appropriately. For example, some people received their medicines covertly, concealed in food or drink. This was not always supported through a clearly recorded 'best interests' process following an assessment of the person's capacity to consent or refuse their medicines, and then consultation with the person's authorised decision maker. We saw that one person had a letter from a GP in their notes authorising covert medicine in the person's 'best interests'. But this was not associated with an assessment of their capacity or as a part of a best interest's process.

People at the home had been protected from concerns about tissue damage. The registered manager had ensured appropriate equipment was provided to support people and put effective measures in place, such as staff training to help ensure that people's skin was maintained in good condition. There were no pressure ulcers at the home despite the very high level of need and frailty on both floors.

Belle Vue was a purpose built three storey care home. Service areas were on the lower floor, with a general nursing care floor set around a central garden courtyard and a mental health/nursing floor at first floor level. There was a passenger lift to access all floors. The ground floor unit was accessible for people with physical care needs, with wide corridors and doorways and adapted bathing facilities. There was a conservatory and central landscaped courtyard garden other garden areas for people to access. However, on the first floor people with dementia were not supported to maintain their independence by the physical environment of the home.

People living with dementia or cognitive impairments had limited information available to help them make sense of their environment on the dementia care floor. There were few visual signs or aids to help people, such as a pictorial menu or activity choices in use. Doors to the toilets had pictorial signs, but there were no direction indicators to help people unless they found the toilet themselves.

People were not using the outside space on the day of the inspection although it was a fine day. One person spent quite some time upstairs looking out of a floor height window and commenting on what they saw. Staff told us that people on the first floor unit did not like to go out. One staff member said that one person went into the courtyard for an occasional cigarette but "others won't even get into the lift, because they're so used to being up here they're scared to get into the lift." This told us that people on the first floor had little access to outdoor space. We did not see any evidence to show how the home were managing this or working with people individually to offer them opportunities to go outside in a way that was supportive.

People were offered a well-balanced diet, but there was poor monitoring and management of people's eating and drinking. Risk assessments highlighted people at highest risk of poor nutrition and hydration. However fluid balance charts and food charts were not completed in sufficient detail to ensure that people received the fluid and nutrition they needed. Charts we saw comprised lists of foods eaten, but did not include quantities. We were told the charts only recorded food and drink taken at meal times, and that if someone had an additional cup of tea this was not recorded. Charts were not balanced or totalled and there was no system for assessing the fluids taken over a period of days. This had already been identified as a concern by the home's management who had another chart ready to be used to record this more effectively. People we spoke with told us they liked the food although one person felt it was 'a bit institutional'. Food was cooked on the premises and included fresh produce, fruit and vegetables.

Most people in the general nursing unit needed their meals to be presented in soft or pureed formats due to swallowing difficulties or risks of choking. This was prepared so that people could still enjoy different tastes of

Requires improvement

Is the service effective?

each component of the food they were eating. Some people had their meals fortified or supplemented, and referrals to dieticians were made when people had significant changes to their weight.

People had access to healthcare services, and people's healthcare needs, in particular on the ground floor nursing care wing were attended to, with specialist advice sought where indicated. Files showed evidence of people's access to healthcare services, such as cardiac appointments, speech and language assessments and occupational therapy visits. Records showed where GPs or other visiting professionals had been called and the outcome of their visits. Visiting relatives we spoke with told us they were happy with the staff skills and knowledge. One told us "They know his needs and they are trained to deal with him…I'm happy with staff levels and have seen staff dealing well with people who are distressed…they've got the skills and patience… because of course they can go home at the end of the day."

Requires improvement

Is the service caring?

Our findings

The home was not always caring.

In the dementia care unit, people were not always supported by staff who understood their personal history or life experiences. Some of the care files contained information about people's personal and social history. A member of staff we spoke with was not able to tell us anything about a particular person's history, despite telling us that the person was very demanding of attention and became very distressed at times, which we saw during the inspection. This would have provided useful information to help the staff engage with the person. Staff did not always try to involve people in making decisions, for example about the meals they ate. Staff were seen at breakfast time placing food and drinks in front of people without offering them choices. They told us they knew what people liked for breakfast and therefore did not need to ask them. There was little engagement between staff and people who lived at the home unless it was about a care task. When we saw staff speaking with people however it was done in a kindly manner with affection.

People's well-being was not always supported. We saw people in the dementia unit who did not have shoes, socks or slippers on and some were bare footed all day. People's clothing did not always appear to have been ironed or cared for well. Clothing had been pushed into one person's drawers rather than being folded neatly. This demonstrated a lack of respect for people's belongings. Men were unshaven. One person we saw had faecal matter under their finger nails. We discussed this with a staff member in the first floor unit. She told us that this was 'about people's choices' and that some of the men got very upset if staff tried to shave them and that the lady with unhygienic nails had to be persuaded to have them attended to. There did not appear to be any strategies in use to support people positively with these behaviours, and we did not see staff taking steps to address them.

The staff did not always ensure people were treated with respect for their dignity. We saw one person in the dementia care unit had an episode of urinary incontinence. They were taken away to be changed and the urine was partially cleaned up with towels, but the floor was left damp and there was no disinfectant used. Other people who lived in the unit walked over this area in socks or bare feet before it dried. We saw people who lived in the dementia care unit wore pieces of towelling as clothes protectors where they needed them. This was not respectful of people's dignity or wellbeing.

People's privacy was not always respected. People in bed were visible from the corridors, and two people visible in their beds were wearing pads and nothing else on their lower bodies, with the door open, meaning they were visible to people walking past. Staff repeatedly walked past people's rooms where they were exposed in this way. This told us that people were not always treated with respect, and that staff no longer recognised this as not respecting the individual's privacy or dignity.

People's confidentiality was not always respected as some confidential information about people's fees and payments was included in their care planning files.

Care plans were not available in dementia accessible formats, such as using simplified text or communication the person may understand better. Information on people's individual communication methods in the care plans was brief. A staff member told us they would know from the person's body language or behaviours that they were unhappy. Some specialist tools were in place for supporting people with impaired communication as a result of living with dementia, such as a specialist pain assessment tool.

Some rooms in the dementia care unit also had information about the person on the door, such as their personal biography. This could be read by people in the corridor. Although this information might be useful for people who would use this to orientate themselves or identify their own room, in one instance the person was bedbound and unable to use this information so it was not clear who this was for.

On the general nursing care floor staff spoke quietly to people and used lowered tones when asking if people needed support for their personal care. Staff knocked on people's doors before entering and closed the door for privacy when delivering personal care. We saw instances where staff interacted positively with people, and where they demonstrated affection for their well-being. For example, we saw one person was seated in the entrance foyer with a relative. A staff member came and gave their arm a squeeze and asked if they could get them anything. They made a joke and both parties smiled.

Requires improvement

Is the service caring?

Records were completed using appropriate and respectful terminology, and when we heard staff talking and at handovers they referred to people respectfully. Arrangements were made at the handover on the general nursing care floor to help staff recognise significant events in people's lives. For example on the day of the inspection one person was due to celebrate their relative's birthday, and staff were reminded of the need to ensure they were ready to go out for a meal with them. Staff also expressed concern at one person who had deteriorated over night, and discussed how they could support the person.

Requires improvement

Is the service responsive?

Our findings

The home was not always responsive. We identified concerns in relation to person centred care planning and activities.

People at Belle Vue had very high care needs. For example, only two people on the general nursing floor were regularly able to leave their bed during the day due to poor health and physical frailty. Some people on the general nursing care floor also were living with significant dementia, but their need for physical healthcare now outweighed their dementia care needs.

People's care records did not sufficiently guide staff on people's current care, treatment and support needs. Files contained risk assessments and plans for moving and handling, pressure areas and nutritional status. However it was not always clear what actions were taken as a result of the assessments where concerns had been identified. For example on the dementia care floor one person's file indicated there were concerns over the person's weight loss from March 2014 to till January 2015. There was no further mention of this from January 2015 onwards. A member of staff told us that the person now 'had to eat in the dining room' as they used to put their food down the toilet if they were not observed. The care plan did not state what actions had been taken regarding the concerns about the person's weight and did not state that they had to be observed at mealtimes.

Care plans did not always reflect changes to people's needs. For example one person's assessment of their skin integrity was seen. This had been reviewed regularly, and gave a numerical score for their skin condition. We saw that in June 2014 the person's score had changed. However there was no information for staff on what this meant for the individual, and there was no recorded change to their care plan or record in their monthly review to indicate in which way they had deteriorated.

People's wishes were not always reflected in their care plans. One relative we spoke with told us that he had requested that their relative receive care only from people of the same gender. We checked with a nurse on duty who was not aware of the request and told us that this had not been actioned as it was "not in the person's file that they would want female carers only".

A member of care staff told us that care staff did not use the care plans, and felt the care plans were mainly for the use of the homes management. This meant that staff might not understand people's social or care needs or how they wanted to receive care, treatment and support.

This is a breach of Regulation 9 (1) (3) (b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person's needs had been assessed before they moved into the home. This was to make sure the home could meet the person's needs and expectations. People and their relatives were able to contribute to the assessment and care plan as much as they wished. One relative told us they were "very, very involved" in their relatives care planning. Plans were being reviewed every month along with the completion of a dependency assessment which identified numerically whether the person had improved or deteriorated. The registered manager and regional manager told us that the home was implementing new care planning systems within a fortnight of the inspection. These were much clearer and would remove outdated information for archiving.

People in both units did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. The provider had not used information about the person's life, past employment, and their interests to develop individual ways of stimulating and occupying people, and engage them in activities that were meaningful to them. Information provided about the service to people said Belle Vue encouraged people to follow hobbies and interests, and that specialist activities such as reminiscence therapy, complementary therapies and sensory experiences were also used to good effect. We did not see this in place.

A member of the inspection team spent time with individuals for much of the morning. During this time staff did not at any point try to distract people from their repetitive behaviour or offer them alternative ways of spending their time. There was an activity on offer in the morning in the first floor unit which was nail care. This was carried out more like a care task than a 'pampering session'. This told us people's experience of care and treatment was more task centred than in response to their individual needs and preferences.

Requires improvement

Is the service responsive?

The corridors in the first floor unit were themed. One had a musical theme, with musical instruments on display; another had a gardening theme and another theme of old film stars. People did not interact with the displays and were not encouraged to do so by staff that we saw. People who lived in the first floor unit who were not wandering were either sitting in one of the lounges or remained in their rooms. A number of those in their rooms were engaged in repetitive behaviours such as rocking or moaning. We did not see any interventions being undertaken with them. We visited one older person in their room, who was living with significant dementia. They were in bed with a badly tuned radio on, tuned to radio one. A member of domestic staff came into the room, but did not follow the person's care plan, in that they did not introduce themselves to the person or explain what they were doing there. The person was unable to share their experiences with us as they could not express themselves verbally, and were bedbound, so were not able to control their environment in any way.

People did not have access to specialist dementia activity equipment such as sensory aprons or other activities during the inspection. A member of staff told us that one person liked folding things but we did not see staff provide this person with anything that would support this to happen. Staff told us about some of the ways they supported people living with dementia. A nurse told us that people had memory boxes to help staff engage with people about their lives, and we asked to see one, but it could not be located.

Some people who lived at the home in the dementia care unit were younger people with an early onset dementia. These people were in some instances physically fit, but we could not see that they were offered any significant physical activity to help reduce any stress or frustration. Staff told us about the difficulties they experienced in engaging people with activities. One said "The activities co-ordinator is on holiday this week; they do themed things and arts and crafts. But there's a lack of interest and people often disengage before the end of the activity. They could not do a whole board game they just get up and walk away. A lot is her doing stuff and them watching." This told us that activities may not always be aimed at an appropriate level to meet people's individual needs and interests. Staff did not demonstrate an understanding that stimulation and engagement for people could be carried out as a part of all interactions throughout the day.

Requires improvement

Is the service well-led?

Our findings

The home was not always well led. The home's management had not demonstrated effective leadership in developing a positive vision and culture of care, or implementing the findings of internal quality assurance assessments. Staff in the dementia unit had become acclimatised to poor standards of dementia care, and management had not demonstrated effective challenge and oversight of standards.

In the home's PIR they told us "We operate a strong leadership model which includes specific leadership training delivered by external specialists. Quality is integral to the services we provide and our person centred care planning process helps identify risks to the service to individual residents. We also have a dedicated national quality team who drive continuous improvement. In addition we operate a fully independent audit team which reports directly to our Board of Directors."

We found that the governance systems in practice were not robust enough to enable the registered person to monitor and address quality issues or address risk. We identified concerns in relation to risk assessments and risk management, recruitment, staffing, management of medicines, staff skills and knowledge, supervision and appraisal, implementation of the MCA and Deprivation of Liberty Safeguards, recording of people's food and fluid intake, care planning, activities and the adaptation of the environment to support people with dementia. The majority of our quality concerns were related to the operation of the dementia care unit.

Although the provider had identified some issues relating to dementia care through an internal company quality assessment undertaken in November 2014, sufficient actions had not been taken to address these shortcomings. For example we saw that the assessment had identified concerns over a lack of engagement between people living at the service and the staff and lack of stimulation for people in their rooms. We found this was still the case on this inspection. Minutes of a clinical governance meeting held in June 2015 showed that a senior person from within the company who visited had identified that carers needed to be 'reminded again' about interacting with residents, as they were seen talking between themselves and "ignoring residents". We found this was still the case on our visit.

The registered manager communicated with the staff team through regular staff meetings to ensure that information about the service was shared among the staff group. Staff told us that senior staff were available for much of the time on the units and were available if they needed any support. Handovers were held between shifts to ensure information about people's changing needs was passed on, and training had been delivered to staff in supporting person centred care and good dementia care practice. However, we did not see that the leadership from the home's management team had supported the development of a positive culture of good dementia care. We saw examples of where care staff did not recognise or acknowledge poor care happening, for example, staff regularly walked past people in distress without acknowledgement or past people who were physically exposed without this being addressed. Staff identified people's care plans as 'something that management did' and not a primary tool for ensuring consistent care in line with people's wishes. Training was not consistently consolidated through supervisions or the modelling of good practice as a way of sharing the ethos and philosophy of care of the unit.

The registered manager carried out a series of audits which were specified by the provider organisation throughout the year to assess and monitor the quality of care that people experienced. These included audits of practice in relation to medicines, infection control, falls care documentation, people's experience and skin integrity. Spot checks, for example of medicines management were carried out. Incidents or accidents were analysed to see if they could be prevented in future. This included the use of 'distressed reactions reports', which included an identification of the person's behaviour and circumstances prior to an incident to assess the cause where possible. As a result of these audits some issues had been identified and actions taken or had been planned, for example new fluid balance charts and new care plans. Feedback from the falls audits had identified there was a high level of falls between 3-6pm. The home changed the provision of activities to be held later in the day and found there had been a decrease in the number of falls people experienced.

Questionnaires were sent to stakeholders, and the results analysed and action plans drawn up where potential improvements were identified. For example concerns had

Requires improvement

Is the service well-led?

been expressed over the way that laundry was managed. As a result, Belle Vue employed a Housekeeper to be in charge of domestic and laundry staff, and put in place in-house training to improve the standards.

However despite these systems being in place, we saw their impact on quality of care issues had not been sufficient to prevent poor care occurring. We identified significant concerns over the quality and safety of the service that people, in particular on the dementia care floor experienced, some of which had not been previously identified and others had not been resolved. We found that systems and practices had been established but not operated effectively to improve the quality of care and service for people.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager chaired quality governance meetings and heads of department meetings within the home. Minutes were kept of these meetings to enable staff to reference them, to see what had been discussed and who was responsible for taking actions to improve; however some of the minutes we saw were brief notes only. The registered manager and other senior staff also attended matrons meetings with local community teams and regional meetings within the company to discuss and share best practice.

People told us that the registered manager was approachable and available to discuss any concern they may have. The registered manager's office is located close to the front entrance and the service user's guide indicated the times that she was available for people to see her. People's ability to give quicker feedback was to be improved as in the weeks following the inspection a new tablet computer was to be installed in the entrance foyer to support people to give feedback to the manager about their experiences. This told us that the home was pro-active in seeking ways to gather feedback from people about the quality of the services provided.

Staff were positive about their experiences of working at the home. A senior staff member told us "I love it here. It has its challenges, but then it would be boring, and I like to be challenged" and a care staff member said "The management is good, if we have any problems or issues like if we need certain days off or whatever she'll work with us so that good".

People told us "It's an excellent home…the staff are very pleasant and efficient, it's nice and clean and it runs beautifully. I'm always made welcome and she's happy here." and 'They're dedicated…they have to be to do the job, and the staffing is stable.'; 'I am totally happy, I trust them here.' and 'The staff are very good.'

Records were maintained securely in offices on each floor of the home. People's care files were unwieldy, some handwriting was hard to read and files contained significant information that was outdated. This meant it was difficult to identify people's current needs easily. Policies and procedures were available to staff in offices or from computerised systems. There were facilities for the secure destruction of records on site.

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 **Risks to people had not always been fully assessed or actions taken to reduce or manage risks.**

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 provider had not ensured the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures had not been operated effectively to ensure people were protected from being cared for by people who may be unsuitable.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had potentially deprived individuals of their liberty without lawful authority as they had not made appropriate applications under the deprivation of liberty safeguards.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems to assess, monitor and improve the quality and safety of the services provided were not being operated effectively.**
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured that care planning reflected people's changing needs and wishes.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.