Belle Vue Healthcare Limited

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Bellevue Healthcare Limited on 22 February 2017. This was an unannounced inspection which meant staff and registered provider did not know we would be visiting.

Bellevue Healthcare Limited is registered to provide care and support to 102 people. Three of the units at the service were being used. These were the Amara Unit which provided care and support to people living with a dementia, a unit for older people who required predominantly residential care but some people needed nursing care and a third unit for young adults living with a physical disability. The unit for older people requiring nursing care was closed. At the time of the inspection 36 people used the service.

A new manager came into post in September 2016 and became the registered manager in November 2016. A registered manager is a person who has registered with the Care 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.

The last comprehensive inspection of the service was completed on 21 March, 5 and 18 April 2016. We found multiple breaches of our regulations and judged the home to be rated as inadequate. The service has also been under a serious concerns protocol with the local authority since March 2016.

In June 2016 we issued a fixed penalty notice because no registered manager had been in place for over a year. The registered provider paid the £4000 fine in order to deal with this breach.

We have carried out a further four inspections of the service with these taking place in May 2016, September 2016, October and November 2016 and in December 2016. These have occurred either because of growing concerns about people's safety or because other visiting professionals were finding improvements. Consistently we have found that the action the registered provider has taken to address the breaches of regulation had not been effective. At times we have found the level of risk posed to people who used the service had increased. At other times we have found some improvement but this was not sustained.

We have repeatedly found that when people received food and fluid via Percutaneous endoscopic gastrostomy (PEG) this was not managed in line with their prescriptions. A PEG is a means of feeding when oral intake is not adequate, for example, because difficulty when swallowing. Also we found there was conflicting information in the care records about the volume of the additional fluids the individuals' required. Records of PEG balloon checks showed these were not reviewed as required. Although we asked the registered provider and registered manager to take action on follow up inspections we have found the same problems continued to occur.

At the first inspection 21 March, 5 and 18 April 2016 we identified that when people were underweight staff were not contacting GPs and dieticians about this matter. In September 2016 we found people were grossly

underweight and at risk of being malnourished and developing a compromised immune function; respiratory disease; digestive diseases; cancer and osteoporosis. We found following our raising of this issue at the first inspection staff were referring people to dieticians but had not re-referred individuals when they continued to lose weight and their BMI were extremely low. Staff had not weighed people on a regular basis. At the November and December 2016 inspections we found staff continued to inconsistently monitor people's weight and were not demonstrating that they took action when individuals were not eating and drinking sufficient.

From the first inspection in 21 March, 5 and 18 April to last inspection in December 2016 we routinely found that wound care has not been effective; the requirements of the Mental Capacity Act 2005 have been inadequately followed and this compromised people's safety; medication practices remained unsafe; care records were inaccurate and staff failed to demonstrably take action when people have not been eating or drinking. The governance arrangements have not been effective or supported staff to resolve any of these problems.

We asked the registered provider and registered manager on two occasions to investigate the discrepancies around the insulin administration.

We have reported a number of concerns to the local safeguarding team around poor management of PEG regimes; medication practices; people's compromised nutritional status; and wound care.

Following our visit on the 5 September 2016 we required the registered provider to take immediate action to ensure people's health and safety was not compromised.

In November 2016 we issued an urgent NOD for the registered provider to review the fitness of one of the directors. This was because we found that they were inappropriately completing and signing, as senior consultant, 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) papers. This required the registered provider to investigate why one of the Directors was signing these papers and to review the role of the clinical lead. Subsequently the Director stepped down from the company.

In November 2016 we also issued an urgent Notice of Decision, which imposed several conditions on the registered provider's registration. These required that no one was admitted to the home without first discussing this with us at the Commission, that action be taken to manage risks identified for two people around their hydration and compromised gag reflex and that staff completed capacity assessments for these two people. The conditions also required that the registered provider assessed the competency of all the staff deployed at the home and where necessary took action to ensure staff performed to an acceptable standard.

At this inspection we again found that where people refused to drink sufficient fluids staff did not demonstrably take action to contact GPs and other healthcare professionals to help reduce the potential conditions associated with dehydration. The registered manager told us when staff had contacted the GP about people not taking sufficient fluids for three days they had been shouted at and told not to call the surgery. No records were available to show when this occurred or that the GP had behaved in this manner. No baseline thresholds were recorded on care plans so we could not determine how staff would know when the GP needed to be contacted.

Staff continued to fail to understand how to apply the requirements of the Mental Capacity Act 2005 (MCA) and allowed people who lacked capacity to make high risk decisions. An example of this was that staff allowed people to eat normal food when the Speech and Language team had advised against this because

they were at significant risk of choking.

We found that although action had been taken to improve the way PEG feed regimes were managed. Prescription details were still being inconsistently recorded in the care record and the administration record sheet. There were no measures in place to monitor the administration of PEG feeds and so staff could not readily demonstrate feeds had been given. The records of the volume of fluid to be given each day were confusing.

We found that it was unclear how wounds were being treated, why dressings were changed less frequently than required for instance the daily records for one person stated they needed dressings changed every three to four days but the dressings had not been changed for seven days.

Again we found that actions identified in audits and incident reviews were not completed. For instance care plan audits identified that the records were inaccurate and needed updating but staff had not completed this work. Records continued to show that people were mobile and used commodes when they were not or loved ones were still alive although they had died some time ago.

We found that staff had been reviewing care records and risk assessments to ensure they were more person-centred and accurately reflected people's needs. However, as both the registered provider and registered manager acknowledged this work was not complete.

We found that a new system for medication administration had been introduced, which was computerised. It alerted the registered manager and pharmacists to the need for new stock and when deviation from prescribing guidelines occurred. We established that stock balances were correct. However, we found improvements were needed to the way topical creams and 'as required' medication was managed.

We reviewed the training records for all nurses and care staff and found that no area of training was up to date for all staff. This meant that we could not be sure if staff were competent to provide care and support to people. Also we noted that not all of the staff completing PEG feeds had received training to complete this activity.

Staff could not find people's records for food and fluid from the previous week and we were informed that they had been archived. We looked through the most recently archived material and found the information was not there and the records we saw were not in date order. We pointed out at the last inspection this was problematic as staff could not be assured that they had a good oversight of changes in people's needs; the material was used to compile accurate care plan evaluations; or that action had been taken when needed.

There were sufficient staff on duty to meet the needs of people who used the service. We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

The service had a clear process for handling complaints.

We found the registered provider was continuing to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified during the inspection on 21 March, 5 and 18 April 2016. These breaches related to safe care and treatment, consent, person-centred care, nutrition, safeguarding, staffing and governance. The overall rating for the service at that inspection was 'Inadequate'. At this inspection the overall rating for the service remains as 'Inadequate'. Therefore the service will remain in 'Special measures'. Services in special measures will be kept under review. The expectation is that providers found to have been

providing inadequate care should have made significant improvements within this timeframe. We are taking action in line with our enforcement policy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff failed to recognise when poor practices should be reported to local authority safeguarding teams.

Risk assessments were not always in place where needed.

Care plans did not always accurately reflect people's health needs and risks.

People's health, safety and wellbeing continued to be at risk, especially in relation to people who had compromised gag reflex and risks of dehydration.

Is the service effective?

Inadequate

The service was not effective.

People's consent was not sought at all times. Staff did not follow the requirements of the Mental Capacity Act 2005 and this left people vulnerable to harm.

Not all of the staff had received all of the mandatory training. Despite us raising concerns regarding managing PEG feed regimes, wound care and safeguarding, staff still had not received adequate training in these areas.

Staff felt supported by their colleagues and the registered manager and staff worked as a team.

People were provided with a choice of nutritious food but staff needed to demonstrably take action when people did not take sufficient fluids.

People's on-going healthcare needs were monitored and staff working with healthcare professionals in the community.

Is the service caring?

Good

The service was caring.

Staff knew people and cared about them.

We saw that the staff were empathic and supported people to manage their daily lives.

Staff were considerate of people's feelings and treated people with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and care plans were produced but these were confusing, inaccurate and difficult to use.

We saw people were encouraged and supported to take part in activities.

The people we spoke with were aware of how to make a complaint or raise a concern

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider was developing better systems for assessing and monitoring the performance of the service.

Although the registered provider and registered manager were taking action to improve the operation of the home further work was needed.

Bellevue Healthcare Limited

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 22 February 2017. The inspection team consisted of three adult social care inspectors, a pharmacist inspector 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.

We reviewed information we held about the service, including the notifications we had received from the registered provider and complaints made about the service. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted external healthcare professionals and the placing authority commissioners to gain their views of the service provided at the service.

We spoke with 12 people who used the service and three relatives. We spoke with 12 members of staff, including two of the directors, the registered manager, a nurse, senior carers, five care staff, an activity coordinator, the cook and kitchen assistant. We looked at ten care records, Medicine Administration Records (MARs), six staff files, including recruitment records, as well as records relating to the management of the service.

We looked around the service and went into some people's bedrooms (with their permission), all of the bathrooms and the communal areas. We observed how staff engaged with people during activities.

Inadequate

Is the service safe?

Our findings

At all of the previous inspections we found that peoples' medication was not administered safely, which meant that the registered provider was in breach of Regulation 12 (Safe care and treatment), of The Health and Social Care Act (Regulated Activities) Regulations 2014. For instance, at the inspection in April 2016 we found records relating to medication were not completed correctly placing people at risk of medication errors. Medicine stocks were not properly recorded when medicines were received or when medicines were carried forward from the previous month.

At the May and December 2016 inspection we found people's insulin was not administered in line with the prescription. In the November 2016 inspection we found that the process for auditing medication was ineffective and led to staff not taking action when there were discrepancies in the stock balances.

In December 2016 we found a new system for medication administration had been introduced, which was computerised. The system was introduced to improve safety and compliance in administration of medicines. We could see reports on why medicines were late, who was prescribed antibiotics, which staff had completed a medicine round and the time it took. The system alerted the registered manager if a medicine was missed and would not allow a medicine to be administered if it was too early, for example not leaving four hours between each Paracetomol administration. It alerted the registered manager and pharmacists to any deviation from prescribing guidelines and when stock was running low. However, it only became operational on 3 December 2016 so reports and alerts had yet to be produced.

At this inspection we found that appropriate arrangements were in place for recording of oral medicines. Staff had completed medicine administration records correctly after people had been given their medicines. When people had not taken their medicines, for example if they refused or did not require them, then a clear reason was recorded.

The system had helped staff in January 2017 to identify that a box of codeine phosphate had gone missing. The registered manager was still investigating this matter.

Several people were prescribed creams and ointments. Care staff applied many of these when people first got up or went to bed. We saw the service had introduced a system that included a body map that described to staff where and how these preparations should be applied. We saw examples of these records; however, some were still not fully completed. These records, when completed, help to ensure that people's prescribed creams and ointments were used appropriately. The registered manager told us they were still working on improving these records and ensuring they were always completed.

We found that where medicines were prescribed to be given 'only when needed,' guidance to inform staff about when these medicines should and should not be given was now in place. However, we saw that the guidance had not been updated when the dose had changed. This information, when up-to-date, helped to ensure that people were given their medicines in a safe, consistent and appropriate way.

Medicines kept at the service were stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators that stored items of medication. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered.

For a medicine that staff administered as a patch, a system was in place for recording the site of application and this was fully completed for one person whose records we looked at, however we could not be sure that the application site had been rotated. This is necessary because the application site needs to be rotated to prevent side effects.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. The registered manager completed regular audits that had identified some of the same issues found during our visit and put action plans in place to address these matters.

Risk assessments had been improved since our last inspection but the registered manager recognised further improvements were needed. Some of the risk assessments we reviewed were detailed and set out clear plans to help keep people safe. For example, one person had a risk assessment in place for the use of bedrails to keep them safe when they were sleeping. This had been updated in February 2017. Although we saw that other people's care plans lacked risk assessments, this had been identified during an audit and work was underway to update them. In some care plans we saw that risk assessments were in place when they were not needed, such as for personal care when there was no obvious risk to the person. And other people's risk assessments were out of date as they indicated that people were still mobile when they were not.

At this inspection we again saw that staff were recording fluid balances for people and noting their intake and output. However, when people drank below the recommended amount there was no evidence to show action was taken to contact healthcare professionals. People were recorded as consuming between 300mls and 950mls of fluid per day but no record was maintained of the action staff had taken to encourage individuals to drink or to make contact with GPs and other healthcare professionals. The registered manager informed us that when staff had contacted the GP about people not drinking for several days they were shouted at and told not to ring about this again. However, there were no records to confirm this had occurred. When we spoke with staff they told us that nothing could be done if the person refused to drink .We discussed with the staff the use of subcutaneous fluids to assist people to increase their fluid intake. They felt it was not in the best interests of people to use this technique to improve fluid intake.

None of the care records identified that even mild dehydration adversely affected mental performance and increased feelings of tiredness. Mental functions affected include memory, attention, concentration and reaction time. Common complications associated with dehydration also include low blood pressure, weakness, dizziness and increased risk of falls. Poorly hydrated individuals are more likely to develop pressure sores and skin conditions. Water helps to keep the urinary tract and kidneys healthy. When fluid intake is reduced the risk of urinary tract infections increases. Inadequate hydration is one of the main causes of acute kidney injury. Staff we spoke with did not outline any of the risks associated with dehydration.

We had highlighted this issue during all of our inspections, but staff still did not record how they were dealing with risks associated with dehydration and malnutrition. Staff continued to accept that it was acceptable for people to refuse fluids and did not look at alternative approaches they could adopt.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Over the course of the last year staff made referrals to the safeguarding teams in relation to incidents where people who used the service had become agitated. However, they had not made referrals in relation to staff omitting to administer PEG regimes, identify weight loss issues, deal with wound care issues and ensure people received adequate food and fluids. Previous inspections to the service had identified that the registered provider was in breach of Regulation 13 (Safeguarding service users from abuse and improper treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite concerns being persistently raised around staff not reporting safeguarding incidents to the local authority we found that staff training was not up to date. Out of the 85 staff shown as currently employed at the service 52 staff had completed this training with the majority (32 staff) having undertook the training in April 2016. Five staff had not completed the training since July 2015.

Staff told us that in January 2017 they had all received supervision sessions that covered the registered provider's expectations around safeguarding. They told us this had also been discussed in staff meetings. Staff told us that they had been given clear information about the necessity to recognise and report safeguarding incidents. They knew that not ensuring people had adequate food and fluid, for example, constituted abuse. Staff were able to outline the steps they would take if they witnessed abuse. Staff were able to describe how they ensured the welfare of vulnerable people was protected through the organisation's whistle blowing [telling someone] and safeguarding procedures. However, we still found that external parties, rather than staff, were reporting incidents relating to poor staff practice, such as not contacting GPs in a timely manner and inappropriately managing risks.

The registered provider confirmed safeguarding and whistleblowing policies and procedures were in place. We saw they followed the safeguarding policies produced by the Tees Valley local authorities but had their own whistleblowing policy.

This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

In the 21 March, 5 and 18 April 2016 inspection we found that there were insufficient staff deployed to meet the needs of the people who used the service, which meant that the registered provider was in breach of Regulation 18 (1) (Staffing), of The Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection the general opinion from people and relatives we spoke with was that although staff seemed to be rushed at times nobody felt that they personally had suffered from this and concluded there were enough staff. One person said, "There are enough (staff) for what I need, maybe they could do with more at night." Those who used the call bell system said they were happy with the response time from staff. One person said, "Yes, the response can be five minutes or shorter, it's rare to be longer."

From review of the rotas and discussions with people and staff members, we found that there were enough staff on duty to meet the needs of the people who used the service. For the 36 people who lived at the service there was one nurse, two team leaders and ten to 12 care staff on duty during the day. Overnight there was a nurse, one senior care and five care staff. In addition to this, the registered manager had been working seven days a week. One to two activities coordinators, three catering staff, two domestic staff and a laundry staff member worked each day. Two maintenance staff worked at the service covering five days a week.

At the December 2016 inspection we found that the registered provider had introduced a new accident and incident reporting procedure. We found that accidents and incidents on the dementia unit had been regularly reported by staff; however no accidents or incidents had been reported on the young people and elderly care units.

At this inspection we found that a computerised system for analysing accidents and incidents had begun to be embedded. We saw staff were starting to record accidents and incidents that occurred not only on the Amara unit but across all units.

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. For example, Disclosure and Barring Service checks (DBS). These are carried out before potential staff are employed to confirm whether applicants had a criminal record and were barred from working with people.

Personal Emergency Evacuation Plans (PEEPs) were in place. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

We saw maintenance records which confirmed that the necessary checks of the building and equipment were regularly carried out. Equipment such as hoists had been regularly serviced. The service had an up to date gas safety certificate and comprehensive COSHH (control of substances hazardous to health) assessments were carried out six monthly. Portable appliances testing (PAT) had also been completed on all relevant electrical items. These checks helped to protect the health and safety of the people using the service.

Inadequate

Is the service effective?

Our findings

At the 21 March, 5 and 18 April 2016 inspection we found that fewer than 75% of staff had received training in fire safety and moving and handling. Fewer than 40% of staff had received up to date training in infection prevention and control, health and safety, first aid, safeguarding, equality and diversity, deprivation of liberties safeguards and the Mental Capacity Act, nutrition, behaviours which challenge, epilepsy, diabetes, Autism and Huntington's disease. Staff had not received any training in end of life care, Dementia, stroke, pressure area care, falls and records. This was a breach of Regulation 18 (2) (Staffing), of The Health and Social Care Act (Regulated Activities) Regulations 2014.

At the time the registered provider took some action to address this but we were concerned about the volume of training they had planned to cover in one session. In one training session the plan was to cover health and safety, COSHH, equality and diversity, fire safety, food safety, moving and handling, safeguarding and complaints training. A superficial level of information was given to staff during this training and a system was not put in place to check that staff understood the training and applied it to their own practice.

We completed a further inspection on 5 and 15 September 2016 because concerns were still being identified and we wanted to make sure people were safe living at the service. We identified that four people were grossly underweight and all had Body Mass Indicators (BMI) of below 18. This shows that people are at risk of being malnourished and developing a compromised immune function, respiratory disease, digestive diseases, cancer and osteoporosis. One person had a BMI of 12, which placed them at very high risk of developing life threatening health conditions. Despite referring people to dieticians in July 2016 the staff had not recognised that people continued to lose weight and that their BMI were extremely low. Staff had not got back in touch with the dieticians.

At the inspection in October and November 2016 we found that when people lost weight staff were still failing to ensure referrals to dieticians were consistently made. During this inspection, we identified that the service was still failing to appropriately recognise and respond to people who were at risk of malnutrition and dehydration. Safeguarding alerts had still not been raised by staff for people at risk of malnutrition and dehydration.

In May, September and November 2016 we found that staff continued to make the same errors and people who used the service were not receiving safe care and treatment. The main reason for this was that staff did not have the skills and competency to deliver safe care and treatment, manage risks appropriately, ensure PEG feed and wound care regimes were followed, apply the requirements of the Mental Capacity Act 2005 (MCA) or recognise safeguarding issues.

In November 2016 we issued a second urgent Notice of Decision (NoD), which imposed several conditions. These were that no one was admitted to the service without first discussing this with CQC, action was taken to manage risks identified for two people around their hydration and compromised gag reflex, that staff completed capacity assessments for these two people, the registered provider assessed the competency of all the staff deployed at the service and where necessary took action to ensure staff performed to an

acceptable standard.

Following the receipt of this Notice the registered provider and registered manager, with assistance from external consultants, completed a review of the staff competency and provided evidence to suggest staff were generally competent. They identified that some staff needed additional support and produced action plans showing how this additional training would be delivered.

At the December 2016 inspection we found that staff had been participating in training, however not all staff were up to date with their mandatory training. We reviewed the training records for all nurses and care staff and found that no area of training was up to date for any of the staff. This meant that we could not be sure if staff were competent to provide care and support to people. The registered provider and registered manager told us that they were currently looking at their training provision to assess how they could match training to particular learning styles. They told us that they would also introduce regular staff competency checks.

At this inspection we reviewed the training records for all nurses and care staff and again found that no area of training was up to date for any of the staff. This meant that we could not be sure if staff were competent to provide care and support to people. We were contacted by relatives of people who had previously been at the service who told us they found the staff did not understand how to deliver care that met peoples' needs. Also we noted that areas of practice we have consistently highlighted have not been addressed. For example, where staff needed further training on application of the MCA, safeguarding, PEG feeding and wound care.

We found that five out of the 12 staff completing PEG feeds had received training to complete this task. Although we raised concerns in September, November and December 2016 about how PEGs were managed we saw no additional training had been provided. Records showed that three of the trained staff last received training in April 2016.

Three out of 12 staff responsible for wound care had received training in this area. Two staff attended a course in September 2016 and one in December 2016. We found 54 of the 89 staff had received safeguarding training. Seven staff last completing this in July 2015; one in November 2015; 34 staff completed this in April 2016; and the remaining 12 staff received this training in October 2016. In terms of MCA training 36 of the 89 staff had completed this training. Of these staff 18 had last completed the training in 2015. Two of the three nurses who completed the training did so in July 2016. Two staff had completed this training in January 2016 and the remaining completed this in October 2016. We found action had not been taken in response to the serious concerns we raised in November 2016 to ensure staff were trained to meet the needs of the people who used the service.

This was a continued breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We found at the inspection in November 2016 that one person who received food and fluid via Percutaneous endoscopic gastrostomy (PEG) was not being given adequate fluids. A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate, for example, because of difficulty swallowing or sedation. We saw a dietician's letter dated 16 September 2016, which stated the person must receive 700mls of fluids each day in addition to food and flushes but the person's care records had not been updated. The inspectors noted that the person had not even been receiving the 500ml of fluids per day. We reported this matter to the local authority safeguarding team.

In the December 2016 inspection we found that the person's care plan had been reviewed and updated but this did not follow the times specified in the dietician's letter. The plan recorded that the individual was to receive 250mls of Fortisip at 2pm and 125mls at 8pm. But this should have been the other way around as stated in the dietician's letter. The staff could not tell us why this had changed. Although the person's PEG regime now recorded they were to have 700mls of additional fluid the records showed they were still only receiving 500 to 550mls of fluid.

Another person's PEG regime information did not match that set out by the dietician and there was conflicting information in the care records about the volume of the additional fluids needed.

For two people their PEG regimes were not always recorded as given. Also one person needed their PEG balloon to be checked each Sunday but the records showed this was not occurring as required.

We asked the registered provider and registered manager to take action to ensure people's PEG regimes were followed and that these matters we had identified were reported to the local authority safeguarding team.

At this inspection we found that people who received PEG feeds weights were stable. We noted one person's care plan for eating and drinking had been reviewed and updated to reflect a change in the feeding regime after a discussion with the dietician. However, it was noted that the care plan stated five feeds were to be given a day in addition to flushes. The regime sheet detailed that only four feeds were to be given. We pointed out this discrepancy to the registered manager who explained the person had gained weight so the dietician recommended a reduction in the number of feeds. They acknowledged this should be reflected in the care plan.

We found there was no stock control process in place for the management of the PEG feeds therefore no one could complete a count to ensure all of the feeds signed for were given.

Separate files were kept in individuals' bedrooms and for people receiving PEG feeds these contained prepopulated sheets with the details of the feeding regime. The sheet included pre-populated information about the volume of fluid to be given. The staff needed to just sign against the sheet to say the fluid and feed were given. There was no other mechanism in place to confirm that the total amount of fluid and feed had been given. When reviewing the pre-populated information we were unsure if entries regarding pre- and post-flush meant the total amount of fluid was to be split between these two processes or whether on each occasion the service user was to have the full amount.

Although we found that action had been taken to ensure staff were aware of the correct percutaneous endoscopic gastrostomy (PEG) regimes and ticked pre-formatted sheets showing they had given the feed and fluids, no system was in place to check the validity of these entries. No audit process was in place and this meant the registered provider could not confirm that people had their feeds and fluids in line with their prescriptions.

We saw that some improvement had been made in the service referring people for dietician support. People's weights were regularly taken and monitored, and staff used recognised tools such as the Malnutrition Universal Screening Tool (MUST) to monitor people's nutritional health. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Where people's weight unexpectedly changed we saw that timely referrals were made to dieticians, and their recommendations were acted on. However we noted that staff still took no action when people refused to have their weight

taken.

This was a continued breach of regulation 14 (Meeting nutritional needs) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At every inspection since March 2016 we have highlighted that staff failed to implement the requirements of the MCA and related code of practice. This was a breach of Regulation 11 (Need for consent), of The Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection we saw staff had been working to address this issue, however, MCA assessments were not consistently completed for people who needed them. For example, we saw that one person had a decision-specific MCA assessment in relation to the use of bedrails but for no other decisions made about their care. Also the mental capacity care plan for another person identified that they lacked capacity to make decisions about residing at the service and about receiving care and treatment. However, these mental capacity assessments were not decision specific and there was no evidence of best interest decisions having been reached.

We found that staff made decisions that people had capacity to make decisions despite their records showing they had a mental health condition, often were forgetful and did not retain information.

We saw in other peoples' care records they were noted to lack capacity but found that they had no MCA assessments in place.

We saw that where people were deemed as having fluctuating capacity, staff failed to understand what this meant for their practice. For example a staff member had completed an assessment for one person and deemed a decision around their food intake to be a 'simple decision'. The staff member had not considered the significant risk of choking presented by eating a normal diet. The staff member judged this person to have fluctuating capacity to make this decision to take risks that could lead to serious or life threatening consequences for them. However they found the person lacked capacity to make the decision to stay at the service, which they deemed a complex decision. We found this assessment of simple and complex decisions incorrect and the decision that could result in them choking was significantly more complex than whether to stay at the service.

All the staff we spoke with told us the person continued, at times, to disregard the Speech and Language Therapist (SALT) team guidance to eat a soft diet. They would insist on eating certain food which had caused them to choke as recently as the week before our visit. We found that although the person was deemed to have fluctuating capacity at the times they wanted to disregard guidance, staff had not considered if this was a capacitated decision. Therefore no additional capacity assessments were completed on these occasions. It is a requirement of the MCA and associated code of practice that for people whose capacity to decide fluctuates, then assessments should be completed when the individual

wants to make an unwise or risky decision. Deciding to eat a food type that could cause them to choke would fall into the category of unwise or risky decision.

We did not see any written records of Best interest decisions being completed in the care plans we reviewed. This was despite the fact we revisited care records for people reviewed at previous inspections were there had been some evidence that Best Interest meetings had been held for the two people identified in the NoD. We saw for these people the records relating to the Best interest meetings had been removed from their files and stored in a disordered manner in archive folders.

We saw that where people who lacked capacity were PEG fed and given medication via this technique, staff had not realised they were covertly giving this medicine. Therefore no Best interest meetings had been completed to seek agreement to give medication covertly.

This is a continuing breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Where people were subject to DoLS these were recorded in their care plans. Records we looked at showed conditions of authorisation were being met. For example, one person's DoLS was authorised on the condition that staff spent one-to-one time talking with the person and that this was documented. Staff showed us records confirming conversations were taking place. Another person had a condition that they were supported to access activities in the local area and records showed that staff regularly offered them the chance to do this activity. The registered manager had introduced a monitoring system for ensuring that DoLS authorisation were renewed appropriately and took action to follow up those that had not been returned or completed.

However we found that because staff failed to understand the requirements of the MCA they were not appropriately identifying when people lacked capacity. Therefore people either were assessed to have capacity when they clearly may not or capacity assessments were not completed when the staff felt someone lacked capacity. This led to DoLS authorisations not being sought when needed.

This is a continuing breach of regulation 13 (5) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Staff were supported with regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff said they found these meetings useful and records confirmed they were encouraged to raise any support needs or issues they had. Staff told us that since November 2016 they had all completed supervision sessions and appraisals. One member of staff discussed the most recent supervision session they had been to, which had covered safeguarding procedures. They found this very useful as it highlighted that important facts about acts of omission (such as not ensuring people received adequate food or fluid) was actually neglect and should be raised as a safeguarding matter.

The people and their relatives who we spoke with during the inspection were generally happy with the support provided by staff at the service.

One person said, "I get on reasonably, it was excellent at first then the regime changed but it is improving now." Another person said, "I don't like being in a home but I have to and it's reasonable, I help out when I can." And another person said, "I have been in three other care homes all rated CQC 'good' but I would rather live in this one."

People received appropriate assistance to eat in both the dining room and in their own rooms. The tables in the dining room were set out well and consideration was given as to where people preferred to sit. People were offered choices in the meal and staff knew people's personal likes and dislikes. People also had the opportunity to eat at other times.

People's dietary needs were well documented and clearly displayed in the kitchen, including any specialist diets such as diabetic, soft or fortified foods. There was a weekly menu in place, but we saw that where people requested something different this was provided. Staff were familiar with people's food preferences. For example, during lunchtime we saw one person was brought casserole and a member of staff said, "I've brought that as I know you don't like sausages." The person said thank you and went on to enjoy their lunch.

Throughout the inspection we saw people being offered drinks and snacks in between meals, and drink stations and fruit bowls were located around the service.

Good

Is the service caring?

Our findings

All of the people we spoke with felt staff were respectful of their privacy and dignity.

One person said "Mostly they treat you like a person." Another person said. "They treat me with respect and are polite and courteous." Another person said, "Yes, treated with respect, they knock on the door and always ask if they can come in." Another person said, "Very good, I like living here."

Relatives told us they thought the staff were very kind. One relative said, "The staff are kind and caring." Another relative said, "I think the staff do care but improvements are needed to make sure people get everything they need." And another relative said, "I can honestly say this (the service) is brilliant. The staff are so caring and they do anything we ask for."

Throughout the inspection we saw examples of kind and caring support being delivered in all the units. In one example, we saw a member of staff ask a person how they were doing that day which then led on to a lengthy conversation about their plans for the day. Staff were attentive to people's needs and comfort. For example, we saw one member of staff asking a person if they wanted to move chairs as the sun had changed position and was shining in the person's face. The person said yes and looked comfortable for having moved.

Staff knew the people they were supporting well, which meant they could have personalised and meaningful conversations with them. For example, we saw one member of staff talking with a person about a holiday they had taken and when the member of staff mentioned a detail the person asked how they knew about it. The member of staff told the person their relative had told them about it. In another example we saw a member of staff talking with two people, one of whom asked who looked youngest of the two. The member of staff joked, "Well I know you were born in [year given] and they were born in [year given] so you are younger. That's a fixed question!"

The staff explained how they maintained the privacy and dignity of the people they cared for and told us that this was a fundamental part of their role. We saw that staff knocked on people's bedroom doors and waited to be invited in before opening the door. The maintenance staff commented "We always knock on doors and never just walk in."

The registered manager and staff showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people very well, including their personal history, preferences, likes and dislikes.

We saw that information about advocacy services was available and when needed the registered manager accessed these services.

The environment was designed to support people's privacy and dignity. All the bedrooms we went into contained personal items that belonged to the person such as photographs.

Requires Improvement

Is the service responsive?

Our findings

During our comprehensive inspection of the service on 21 March, 5 and 18 April 2016, we identified that care plans were not person-centred and lacked the detail needed to provide care and support to people safely and according to their wishes, needs and preferences. Care plans were not always reviewed within the timescales set by the registered provider. People had the same care plans in place regardless of whether they were needed. Some people did not have the care plans in place which were specific to their individual needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

In May, September, November and December 2016 we found that the care plans remained difficult to follow and again some care plans were inaccurate. We found that some people's care records failed to identify the significant risks being posed. A care plan audit for one person highlighted that a risk of choking and complications to nutrition resulting from their health condition needed to be updated in the person's care plan. Recommendations following contact with the SALT team and information about how the person could communicate with people also needed to be included within the person's care plan. However, these had not been completed.

At this inspection although we found improvements were being made we again found the care plans contained contradictory information. Although care plan audits had identified gaps in the plans and inaccuracies the staff had not corrected the plans.

We saw that some improvements had been made to make care plans person-centred. For example, one person had a care plan in place to support them with their behaviour when anxious or distressed. This contained detail of signs that might show the person was becoming distressed and steps staff could take to reassure them. Another person, who lacked capacity to make all of their own decisions, had a personal care plan that guided staff on things they did like to decide for themselves such as the colour of their clothes for the day. We saw that care plans were now reviewed more frequently to ensure they reflected people's current support needs.

A relative we spoke with said they were involved in care plan reviews. They told us, "They (staff) do absolutely everything we tell them to."

New records had been created to help staff more effectively monitor people's support needs on a daily basis, including two-hourly observations, food and fluid intake and personal care delivered. However, we saw that the actual times that people checked were not recorded as entries were made in a template where times were already printed. During the inspection we saw staff regularly discussing people's support needs.

The new care plans were person centred and provided clear guidance to staff about people's varied needs and how best to support them. For example, one care plan for mobility and dexterity informed staff that the person could sit in the chair for up to three hours a day then they must have an hour in bed to minimise the risk of any skin break down. However staff had inappropriately developed a risk assessment for every care

plan intervention, including personal care and social activity. Risk assessments are only needed when the activity in question would present a significant risk of harm such as for choking and falls.

A member of staff we spoke with said, "The paperwork has improved massively. Everything is together now, which makes things easier." Another member of staff told us, "Paperwork has seen a big improvement."

The registered manager continued to audit care plans and highlight where changes were needed but staff still did not act upon this information. For example the audit showed that for one person they were no longer able to mobilise to use a commode and that their spouse had died, but the care plan had not been up dated in either respect. We reviewed the care record and found that no changes had been made so the information incorrectly referred to their spouse as being alive, that they could mobilise and use a commode. We found that other care records remained the same as at previous inspections, so again information was incorrect. Also when people had wounds no care plans were in place to outline how these were to be treated.

At the November and December 2016 inspections we found that people's fluid balance and dietary intake records had been stored in a disordered manner in broken lever arch folders at the bottom of filing cabinets. We found at this inspection that staff continued to haphazardly archive and store documents in folders. Staff on the younger adult's nursing unit could not find the previous weeks fluid balance charts and monitoring records. This meant they could not look at them to review the care being delivered the previous week to determine if any changes in needs had occurred.

This is a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

At the 21 March, 5 and 18 April 2016 inspection we found that there was limited opportunity for people to engage in activities. We found the activities on offer were not suitable for everyone using the service. For example, we could see that Scrabble was aimed at people living with a dementia. During the inspection in May, September, November and December 2016 we saw that although activities occurred most people were cared for in their bedrooms so did not join in.

At this inspection we saw that people were engaged in a programme of activities. Generally, the people who used the service and relatives were positive about the planned activities, "Oh yes plenty, I join in with them it depends what's on." Others had their own reasons for not taking a full part, "I am not an activities person but I know that those who go thoroughly enjoy them". Two activity coordinators were now in place and organised a wide range of activities both inside and outside the home. They provided sessions on each unit. The registered manager told us that people had requested at a recent residents' meeting that activities were provided over the weekend and this was being organised.

Relatives and people we spoke with during the visit told us that if they were unhappy they would not hesitate in raising their problem with the staff. People told us that they knew there was a formal complaints procedure in place and the majority of people we spoke with told us they had not needed to make a complaint. One person said, "No I don't know how to make a complaint." Those people who reported that they had made a complaint used an informal route. One person said, "I am happy to go through an informal process about small things." Other people reported a positive response, "Nowt to complain about except the food and the registered manager is looking into it."

The staff were able to explain what to do if they received a complaint. The complaints policy was displayed in the office and on all floors. We looked at the complaints procedure and saw it informed people how and

who to make a complaint to and gave people timescales for action. The registered manager discussed how they investigated issues. We reviewed the recent safeguarding investigations they had completed and saw registered manager critically reviewed staff actions and the outcomes were clearly reported to the complainant and local authority representatives.

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection completed on 21 March, 5 and 18 April 2016 we judged the home to be rated as inadequate and found multiple breaches of our regulations. The service had been placed under a serious concerns protocol with the local authority since March 2016. The professionals involved in the serious concerns protocol had significant concerns about the registered provider's ability to provide safe care and support to people. An embargo was put in place in March 2016 which meant that nobody new could move into the service.

In April 2016, we found that no registered manager had been in place for over a year so we issued a fixed penalty notice for this matter and the registered provider paid the £4000 fine in order to deal with this breach. At that time we took action in line with our enforcement policy and procedures.

In September 2016 we found serious concerns about the operation of the service and required the registered provider to take immediate action to ensure people who used the service received safe care and treatment.

In October 2016 the local authority commissioners told us they believed the service had significantly improved and were looking to start to admit people to the home. We inspected and found that improvements had not been made and people remained at significant risk. In November 2016 we issued two urgent Notices of Decision (NoD). One in relation to the action of one of the directors and another requiring that no one was admitted to the home without first discussing this with us, that action be taken to manage risks for two people, capacity assessments be completed for these two people; and the registered provider assess the competency of the staff deployed at the home.

In December 2016 we noted that external consultants had been employed by the registered provider and were working to assist them to make improvements. Where audits had been carried out by these consultants, action plans had been created and deadlines put in place for staff to make the changes needed to the care records. However we saw these deadlines had passed and the actions had not been taken. Significant numbers of care plan audits had still not been completed; this meant that care plans had not been updated to contain the most accurate and up to date information.

At this inspection we again found the registered manager was open and honest. They recognised that although they were making progress to make improvements this was not complete and many areas still needed to be addressed. Change had been difficult to achieve. The registered provider was working hard to ensure the service improved and the remaining three directors were checking the service's progress. We heard from staff and the people that used the service that the directors were very diligent, were at the home at least three days each week and had been working with the staff at the home to make improvements.

We found that although the auditing systems in place were identifying issues, at times, staff still failed to take the action needed.

We could see that staff had been participating in training, however not all staff were up to date with their

mandatory training. We reviewed the training records for all nurses and care staff and found that no area of training was up to date for any of the staff. This meant that we could not be sure if staff were competent to provide care and support to people. The registered provider and registered manager told us that that they now had plans in place to ensure all staff were appropriately trained and their competency checked. But this was not yet completed.

Staff told us about the recent supervision sessions and how the registered provider was making them aware of their responsibilities.

The service had continued to carry out internal audits. Since the last inspection, a range of audits had been carried out, which included PEG regime checks, wound care checks accident and incident, catering, infection prevention and control, malnutrition universal screening tool (MUST), care plan and health and safety audits.
During inspection, we noted that issues remained present around the safe operation of the service. The registered provider and registered manager confirmed they had also found this to be the case when they had reviewed the service.

We noted that staff had continued to fail to take action when people's weight changed dramatically, as they did not recheck the weight or consider if the scales needed to be recalibrated or replaced. The registered provider told us they had noted this issue and were in the process of buying new scales but this had not been identified in their audits. The audits showed that some people refused to be weighed and expected staff to record information to show that from visual assessment the individual's weight was not compromised and they had no issues eating and drinking. However this was not translated into the care records.

The registered provider and registered manager had introduced a computerised system for monitoring weights, safeguarding issues and accidents and incidents. It was being used to analyse information each month to identify any patterns and trends. We could see that accident and incident records were checked for accuracy during health and safety audits, patterns and trends were now identified and action was being taken, for example, to reduce the potential for people to fall.

Since December 2016 we found that other systems had been put in place but these still needed to be embedded.

This is a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

A registered manager had been in place since November 2016. A registered manager is a person who has registered with the Care 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. People and staff spoke positively about the registered manager, saying she supported them and included them in the running of the service.

One member of staff told us, "[The registered manager] is absolutely amazing, she really is. She's so dedicated and she's put 150% into improving things. We had, to be honest, all been a bit lazy. They have supported us to look at how to do things and always have time for us." Another staff member said, "[Name of registered manager] is making a lot of difference. [Name of registered manager] has focussed on everything and is making positive changes." Other staff members said, "The residents always come first.

[Name of registered manager] is working so hard she stays longer and later and is trying to make everything right", "[Name of registered manager] is very supportive and approachable. I have spoken to her lots of times but she's also not frightened to tell us if something is wrong" and, "The morale is so much better since she (registered manager) joined us. You know if there is a problem you can talk to [Name of the registered manager]."

Staff told us that the company directors visited the service on a regular basis and they were also very supportive. One staff member said, "I can't praise [Names] enough. They are really easy to talk to and so committed to making the home better."

The registered manager was a visible presence around the service, and knew the people living there well. For example, we saw her joking with one person about a song they had been singing at a recent party. The directors were also making daily visits to the service, and we saw they clearly knew people and staff well.

All of the people we spoke with told us that they felt the home was well managed. The majority of people reported that there was a good atmosphere around the home.

One person said, "It's definitely well-managed, particularly now we have got [Name of the registered manager]". A relative said, "She seems quite happy and I am happy with the home it's open and friendly. I don't want to move her." Other people said, "I feel [Name of registered manager] is approachable" and"[Name] is nice and approachable, whatever you ask she will sort it out."

The majority of the people we spoke with did not recall taking part in surveys but the other service users and a relative felt that they were actively involved in the care provided by completing surveys and attending meetings where they could raise issues.

One person said, "I am involved in reviews and surveys. I raised an issue about making sure the night staff came onto the unit at the right times, I am happy with the response."

Feedback was sought from people through resident and relative meetings and via newsletters. Staff feedback was sought in the same way, through regular staff meetings. The registered manager told us that they had started the process of completing an annual survey.